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The International Council of Nurses

NINA D. GAGE, R.N., *President*,

With Suggestions and Much Helpful Criticism from Miss Nutting

FOR the Columbian Exposition in Chicago, in 1893, Mrs. Bedford Fenwick of England came over to America to arrange a nursing exhibit for the British Government. She conferred with Miss Hampton, and an American exhibit was also arranged, and a conference on nursing subjects, with nurses present from several countries. Miss Isabel Hampton was appointed Chairman of this Nursing Section of the Conference on Hospitals, Dispensaries and Nursing by Dr. Billings of the Library of the Surgeon-General of the United States and by Dr. Hurd, then Superintendent of Johns Hopkins Hospital. Miss Hampton herself collected important papers on nursing subjects. She felt very strongly that from such a significant conference, the first of its kind, should crystallize a permanent organization of nurses; and she so enlisted the aid and interest of other nurses that from it did grow the Society of Superintendents of Training Schools for Nurses of the United States, later renamed the National League of Nursing Education. National and international relations in nursing were beginning.

About this time the International Council of Women was also commencing its work, and within the next few years began to be recognized as having an important place in the world. In 1899, its members met in London for their quinquennial convention, and nurses from several countries were among the delegates. Mrs. Fenwick thought that the time was propitious for an international organization of nurses, and broached the subject to members of the Matrons' Council of England, an association corresponding to the Society of Superintendents of Training Schools on this side of the water. The idea was favorably received, the Matrons' Council called a meeting of the nurses then in London, and the International Council of Nurses was organized on July 2, 1899. Nurses from six different countries were listed as Foundation members: England, America, Canada, New Zealand, Australia, and Denmark. A committee drafted a constitution which later was sent to the constituent members for signature.

Objects

WITH slight modifications that constitution, as originally adopted, stood for twenty-six years, and was only revised in 1925 better to adapt the organization routine to the

growing membership. The objects, as stated in 1899, still stand as foundation principles of the International Council of Nurses:

We nurses representing various nations of the world, sincerely believing that the Profession of Nursing will be advanced by greater unity of thought, sympathy, and purpose, do hereby unite in a federation of associations of trained nurses to improve our work in the service of the sick, to promote the health of the nations, and to secure the honor and the interest of the Nursing Profession. . . .

The International Council of Nurses stands for self-government by nurses in their associations, with the aim of raising ever higher the standards of education, professional ethics, and public usefulness of their members.

The International Council of Nurses stands for that full development of the human being and the citizen in every nurse, which shall best enable her to bring her professional knowledge and skill to the many-sided service that modern society demands of her.

The Council aims to provide a means of communication between nurses of various nationalities, to provide opportunities for them to confer upon questions relating to the welfare of their patients and their profession, and to afford facilities for the interchange of international hospitality.

The nurses who helped organize the International Council of Nurses were called Councillors, and their names may be found at the end of every copy of the Constitution, as a roll of honor.

Membership

THE plan of organization of the Council which was to be followed ultimately was for an international federation of national associations of nurses, one from each country, following in this way the example and form of organization of the International Council of Women. But in 1899 nursing associations were not sufficiently well organized in any country, and so the membership of the International Council of Nurses at first included individual members. These "Councillors," as representative nurses from each country, returned home to work for nursing organization. Each country had learned much from the others and it tried to put this new knowledge into practice. Mrs. Fenwick had been elected the first President.

In 1901, at Buffalo, the International Council of Nurses met again, holding its meetings concurrently with the regular meetings of the Nurses' Associated Alumnæ and the Society of Superintendents of Training Schools for Nurses, of the United States. Miss McIsaac, President of the American society, said in her Presidential address:

Our first international gathering in Chicago, in 1893, was marked very distinctly by the making of acquaintance, which sounds rather insignificant, but on second thought assumes its proper place, and we realize that it signified a tremendous force in nursing affairs. The exchange of experiences suddenly roused many women to the fact that the deficiencies and difficulties of their work were peculiar to the whole nursing profession, and not to one school or hospital. To that meeting we owe the greater part of the progress which has been made since then, in America. The second Congress, in London, gave some of our members an opportunity of studying nursing affairs abroad, and was the starting point of definite international relations between nurses; and we will devoutly hope that from this Congress may come as much that is good and stimulating. The problems taken up for discussion on those occasions still confront us on both continents.

The history of the ensuing days is given most succinctly by Miss Dock's report to the Society of Superintendents of Training Schools in 1905 (p. 170):

In order to have the privileges of membership in the great congresses of women, meeting every five years, and which are formed by the National Councils of Women of each country, we joined the National Council of Women of the United States, entering it as the American Federation of Nurses, which we created quite informally, without a written constitution and almost without rules, simply by the adopted

motions of the Superintendents' and Alumnae Associations, to the effect that they would unite in paying the dues to the Council of Women, and would each appoint two members, and that these four members should choose a fifth, who should act as the Chairman and President of the Federation of Nurses. In this simple fashion we have carried it on since then without any trouble, and as the whole international situation was hardly in the budding stage—one might say only a seedling—it has answered so far very well. . . .

The London Congress was held in 1899, and in 1901, still only consisting of individual members, the International Council of Nurses suggested a Congress of Nurses at Buffalo, which you all remember, and which was really a great event in the nursing world. The Berlin Congress of Women last year gave the subject of nursing education a position of prominence. . . .

As to nursing organization, we had also our separate day and place in Berlin. . . . We learned there that England, since the Buffalo Congress, had been organizing nurses with great energy on lines similar to our alumnae associations (called in England leagues), and that these leagues had formed a Provisional Committee looking forward to the definite formation of a national society and affiliation with the International Council. We also found that Germany, quite independently of outside influence (for they had heretofore known nothing of foreign nursing organizations), and entirely as the result of irresistible modern conditions, had formed a national association called the German Nurses' Association, now consisting of over six hundred members and growing daily, which is entirely self-governing, organized, and conducted exactly like our own, and having the same purposes and ideals.

To quote from the minutes of the International Council report of the Berlin meeting, in 1904 (p. 11), from the remarks of the President, Mrs. Fenwick:

We have come here today to hold the first Quinquennial Business Meeting of the International Council of Nurses. Since the Council was tentatively founded in 1899 it has been working on an individual basis, and its members have been striving to forward its objects —the promotion of greater unity of thought, sympathy, and purpose, of international communication between nurses, and of International Conference. The ideal of the Council, however, as Miss Dock has shown, is that admission to membership shall be through National Organizations, and it is satisfactory to be able to report that three countries have now national organizations eligible for affiliation with the International Council of Nurses —the United States through the American Federation of Nurses; England through the Provisional Committee recently formed of Delegates of Leagues and self-governing Nursing Societies; and Germany, through the German Nurses' Association.

These three countries, then, were the charter association members of the International Council—England, Germany, and America.

Other countries have been admitted to affiliation since then as follows:

1909 The Canadian Nurses' Association.
The Danish Council of Nurses.
The Nurses' Association of Finland.
The Nosokomos—Holland.
1912 The Trained Nurses' Association of India.
The New Zealand Trained Nurses' Association.
1922 The National Federation of Belgian Nurses.
The Nurses' Association of China.
The National Association of Italian Nurses.
The Norwegian Nurses' Association.
The South African Trained Nurses' Association.
1925 The Bulgarian Nurses' Association.
The National Association of Nurses of Cuba.
The National Association of Trained Nurses of France.
The National Council of Nurses of the Irish Free State.
The National Council of Polish Professional Nurses.

Dues

DUES at first were assessed at ten shillings per year for each of the four delegates sent by each affiliated association to the Grand Council. Therefore, each member paid an equal amount, whether the association were large or small; $10 in American money, per year, from each affiliated member did not allow the International Council to do much work.

Since 1925, and the revision of the Constitution, dues have been assessed on a basis proportional to the size of the constituent organization—5 cents, United States currency, for each individual member of the member organization, as of January first, each year. Thus if an association has one thousand members, it pays $50 a year, American money, towards the International Council of Nurses. This has given us more money to meet the expenses of enlarged activities, but if we had still more funds we could do much more for nursing.

Organization

THE business of the International Council is carried on by conferences and correspondence between Headquarters at Geneva and the constituent organizations. At the time of each Congress (since 1925, held quadrennially), each affiliated member association may send four duly accredited delegates beside its President, to form with the officers and honorary officers the *Grand Council*, the voting body, a sort of Parliament. Most of the questions to be considered by the Grand Council, including the nominations for new officers for the ensuing quadrennium, are sent to each member four months in advance of the Congress, so that delegates may come instructed how to vote. Since each member organization has the same number of delegates, there is no disproportion in weight of opinion because of size, and this avoids much irritation. This form of organization is familiar to American nurses through their national association, with its House of Delegates, composed of representatives from each state. All program meetings at the International Council Congresses are, of course, open to everyone, and much stimulation is derived from knowing nurses from abroad. This comes to every one attending the Congress, even though only five people from each country actually vote.

To act as an executive committee between Congresses, there is a *Board of Directors*, consisting of the presidents of the national organizations, who are called "National Representatives," and five elected officers, President, First Vice President, Second Vice President, Treasurer and Secretary. This Board of Directors meets just before, and just after, the Congress, and during the quadrennium whenever it is found necessary and possible.

Work

AS outlined in the early meetings of the Council, and summarized by Mrs. Fenwick at the Buffalo meeting (p. 339 of the report), the work of the International Council of Nurses is:

> To draw together the Nursing Councils of the different nations; to diffuse among them professional information from each country which will be useful to all; to unite together and thus strengthen the efforts for professional improvement which may be made in any country, by the assistance and advice of the nurses in other lands. And above all, to arrange for the holding of International Congresses in different countries, on the same grounds as those which have made such meetings so valuable in the past, for the general consideration of important nursing matters, and for the determination of questions which are of common interest and importance to the nurses in every country.

As it has progressed, the work of the Council falls naturally into three divisions:

(a) That for and between the member organizations, and the others in which they have official representatives, but where nursing is not sufficiently organized for affiliation;

(b) That with institutions, government, educational, etc., in all countries, that have inquiries on nursing matters;

(c) That concerned with nurses or people

connected intimately with nursing outside the countries referred to above (in 1928, thirty-one-countries).

The countries where nursing is not yet organized, but where it is a living and growing thing, are looking to the International Council now, as in the past, for help and guidance on their upward path. Very often we can give them useful advice along many lines, including nursing legislation, which will help uphold standards. All this is of course in consonance with the aims of the Council, as outlined in the Constitution, and quoted above. The Council has stood for emancipation of nursing from servitude, of gaining medical and public support for the educational, professional, and economic status. It has tried to bring about from old historic traditions, professional conditions suitable to modern contacts.

Congresses

THE work at first seemed better carried on through Congresses, which have been held as follows:

1893 Chicago—acquaintance with individuals and problems of other countries.

1899 London—preliminary organization.

1901 Buffalo—reports on organization, and stimulation for national work.

1904 Berlin—formal organization on the lines originally intended, of an affiliation of national associations. Adoption of "official organs" of a national nursing press, to disseminate nursing news and views.

1907 Paris—a special conference, with papers on acute problems of the time, such as Progress in Nursing Education, Public and Social Responsibilities of the Nurse, Professional Organization, etc.

1909 London—Closer federation, reception of new members, important papers on Nursing Education, and organization of the Education Committee, with Mrs. Isabel Hampton Robb as Chairman.

1912 Cologne—a stand against the overstrain of nurses, and the employment of non-nurses to be in charge of hospital nursing services. Discussion of various methods in nursing education.

In 1912, Annie W. Goodrich was elected President of the Council, to succeed Sister Agnes Karll, the second President who had served since 1909. The Council accepted an invitation to meet in San Francisco in 1915. Owing to the war, very little could eventually be done, and no meetings could take place. In 1920, a meeting of as many of the Executive Committee as could be present was held in Atlanta, Georgia, at the time of the meeting of the American Nurses' Association. There was, however, no quorum.

1922 Copenhagen—a business meeting was finally held, and Baroness Mannerheim of Finland was elected President for the ensuing triennium. Reception of five new members.

1923 Copenhagen—a business meeting, to plan for the next conference, and transact certain business which could be no longer delayed.

1925 Helsingfors—the great reorganization after the war. Five new members received into affiliation. Representatives from 33 countries united for discussion of mutual problems of education, public health, etc.

1927 Geneva—a conference, only, with a meeting solely of the Board of Directors, not of the Grand Council. Papers on many phases of nursing work, and a reception by the League of Nations.

Committees

SINCE 1925 there have been more committees, and they are trying to do research work on various questions pertaining to the meaning and effect of good nursing, and the best methods of bringing it about. The Standing Committees now are:

Membership—consisting of three members appointed by the Board of Directors. This committee decides on the eligibility of candidates for affiliation.

Program—with the Secretary of the Council as secretary, the other members being

appointed by the President of the nursing association of the hostess country, and approved by the Board of Directors. This committee decides upon, and arranges for, the program and speakers for the next Congress.

Arrangements—appointed by the nursing association of the hostess country, with its President as Chairman. This committee arranges locally for the ensuing Congress, and superintends the registration of delegates and visitors.

Nominations—with three members appointed by the Board of Directors. This committee issues to the constituent organizations blanks on which they shall make their nominations for the officers to be elected at the next Congress. From these nominations the committee prepares a ticket of three or four names for each office. This ticket is sent to each affiliating member at least four months before the Congress, so that delegates may come instructed by their own national associations how to vote. Such a long interval between submission of the ticket and election enables each affiliating organization to consider the matter thoroughly, and prevents "stampeding" of the delegates emotionally or otherwise at the time of election.

Publications—appointed by the Board of Directors, with one member from each continent. This committee decides on the nature and number of publications by the Council. One member of this committee is always to be the Secretary of the Council, and one the editor of the magazine.

Revision—with three members appointed by the Board of Directors, to decide on all matters pertaining to the Constitution and By-laws of the International Council, and whether, also, the Constitution and By-laws of applicants for affiliation are in harmony with those of the Council.

Finance—with three members, appointed by the Board of Directors, who shall advise on the custody of the funds, and their expenditure.

Nursing Education, Public Health Nursing, Private Duty Nursing, Mental Nursing and Hygiene. On each of these committees one representative is appointed by each affiliating country, to report on and discuss nursing activities pertaining to these respective lines, and to stimulate progress. We are hoping for some very illuminating and helpful reports from these committees next summer on the work of their first quadrennium.

Magazine

SOME further work of the International Council of Nurses is carried on by means of its quarterly magazine, *The I. C. N.* (which name will probably be changed at the next Congress). This magazine gives news and articles on all phases of nursing in many countries, whether or not affiliated members of the Council. Most articles are in English, but sometimes a French or a German one makes our international character more apparent. The Editor supplies an English summary for these, for the benefit of those who do not read French or German.

The I. C. N. was first published as a magazine in January, 1926. But its embryo, a multigraphed bulletin, had begun in 1923, and was circulated to the affiliated countries, and representative nurses everywhere, to the number of several hundred. Miss Reimann, Secretary of the Council, at that time studying in America, first made this bulletin possible, with some help in multigraphing and mailing from the national headquarters of the American Nurses' Association. Miss Reimann used to work till the early morning hours, night after night, on her little Corona typewriter, in her room in Whittier Hall, a Teachers College dormitory, where she was working for her Master's degree in Nursing Education. In two years, as only a part of all the work she was doing at that time, she made the Bulletin a necessary organ of the International Council. At the Helsingfors convention it was decided that in view of the high standard and value of this bulletin, not only to the Council, but to nurses everywhere as a means of international communication, a regular magazine must be continued. As Miss Reimann was

from that time to give her whole time to the work of the Council, she thought she could continue as editor of this magazine. And so *The I. C. N.* was born and has continued to this day, keeping up its high level because of Miss Reimann's labor of love. She still edits it as only one of her many activities, but for most other people it would be a full-time task.

The subscription price of *The I. C. N.* for a whole year is only a dollar bill in an envelope sent to the Secretary at Headquarters. Every individual member of the International Council should subscribe, in order to keep in touch with international activities, and to widen her interests. Each member of the constituent organizations is a member of the International Council, and so should feel that the magazine belongs to her. With an increased subscription list, funds would grow which could be used for work not now possible because of lack of money. With affiliated members representing upwards of 95,000 nurses, a subscription list of approximately 1,100 is a condition which should be remedied speedily. This magazine is a great aid in developing "the human being and the citizen in every nurse," and everyone who does not take it loses a great deal of both pleasure and profit.

Headquarters

THE International Council of Nurses has had, since 1925, an international headquarters at Geneva, Switzerland (since 1927, at 14 Quai des Eaux Vives), with a full time secretary, Miss Christiane Reimann, in charge. She replies to all inquiries, conducts certain lines of research, and is always ready to give her statesmanlike aid where it will do the most good. She is already considered in many circles outside of, as well as inside nursing, a great authority on nursing questions, and she has been able to influence nursing progress in many lands.

Library

HEADQUARTERS is collecting, as fast as possible, a library on nursing questions and activities, history, philosophy, and education. We want it to be a center for research and study for anyone interested in nursing. There are now complete files of the nursing magazines of many countries, and some reference books. Gifts to increase the value of the library would be very welcome.

Personalities

TO carry out any work requires great personalities. These we have had in our international nursing leaders who have helped prepare the International Council for us, and have made ready to give to younger hands the torch to lead along the paths of nursing progress. Think of the vision and courage it took, thirty years ago, to write such a constitution, with such far-seeing objects; to formulate plans for an international organization (the first professional and scientific organization to become international); and to work out such a stable organization that it is still running today. Their example may well give us courage to take up our part of the work.

Mrs. Bedford Fenwick of England, who has done so much for British nurses, even since her marriage, was the Founder, and has watched over the Council ever since. Her clear and penetrating mind has seen possible dangers and pitfalls, and kept the Association to the straight path of progress. She has done much to elevate nursing to a position more

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consonant with the heavy responsibilities it bears than it had in the nineteenth century. If nursing education and advancement was finding special difficulties anywhere, it was suggested that if a Congress of the International Council at that place might help, it could go there. When the locality was once decided upon, Mrs. Fenwick would see that distinguished and important citizens of that country knew of the meeting of the Council, and of its objects, and she would induce them to receive the Council in a manner fitting the importance of nursing work. She did much toward making nursing a recognized profession, and toward setting up professional standards. In her own country Mrs. Fenwick has edited, since its foundation, the *British Journal of Nursing*, which she made over in 1902 into a weekly from the *Nursing Record*, which she had edited since 1893. This journal has been a mouthpiece for nursing aims, either in the British Nursing Association, or the International Council, ever since its inception. The rest of Mrs. Fenwick's important services for nursing must be found in the history of her own country.

Miss Breay, the faithful treasurer of the Council for twenty-three years, has done much hard and painstaking work in keeping accounts, watching over financial matters, and guarding the archives. To her we owe much of the preservation of historical data from the confusion of the war years. She and Mrs. Fenwick published, in the *British Journal of Nursing*, a full report of all meetings of the Council. The weekly editions of that Journal were kept up in great part through her efforts through all the struggles in nursing matters during all these years. She labored over the reports and papers, and so vividly presented them that the Congresses live in history. She gives us a graphic record not only of British nursing, but of the progress of the International Council that is an invaluable addition to the formal reports of the Congresses, throwing on these many sidelights without which younger generations would miss much historical color and background necessary to their full comprehension of all that these early leaders did for us.

Miss L. L. Dock, who has helped many American nurses through some of their difficulties in materia medica, was the dynamic Secretary of the Council for twenty-three fruitful and constructive years, kept the records, and helped much in her relations with new associations desiring affiliation. She donated to the Council her royalties on the last two volumes of the "History of Nursing," of which she and Miss Nutting had written the first two volumes, and she alone edited the last two. She kept the minutes and

reports of Congresses, so that nursing history in the making had an adequate record which should make it possible for later generations to visualize the struggles and problems of early nursing.

Sister Agnes Karll was an early member of the International Council on whom the rest depended for counsel and thought in the many problems which came up. She was always cheery, and had always some helpful suggestions. She led the German nurses to professional independence and freedom from the "Mother-houses" of nursing and religious orders which had controlled all their lives, as if entering the profession of nursing were "taking the veil." The struggles are not yet finished over there, but much has been won. The death of Sister Agnes, on February 12, 1927, was a great loss to the profession, not only in Germany, but in the world.

Our own Miss Nutting was one of the Foundation members, and the second Chairman of the Education Committee, following Mrs. Hampton Robb, its organizer. This committee she started well on its way to its present work, helping its renaissance after the war, and as usual giving it inspiration for its present task of helping to raise nursing standards of education throughout the world. At the earlier meetings of the Council she presented important papers on educational questions. She served as the first President of the American Federation of Nurses, in spite of her onerous duties in charge of the School of Nursing at the Johns Hopkins Hospital, so that the United States should have a nursing organization which would permit it to join the International Council, and gain the advantages of international relations. We are anticipating Miss Nutting's vision and stimulation at our next Congress in Montreal, to encourage us for the ensuing quadrennium.

CHRISTIANE REIMANN

Miss Maxwell of New York, and Miss McMillan of Chicago are among others of the American Foundation members who are still with us, to give their help and their counsel where we need it most.

Baroness Sophie Mannerheim of Finland was President of the Council at the last Congress in Helsingfors. She had organized the Finnish Nurses' Association, and made it grow. Finnish nurses had a most influential position in the country, with the Government assisting them in their work. It was inspiring to become acquainted with the charming woman who had been their President for twenty years. She was serving the International Council as President in the same delightful, dignified, and fruitful manner in which she had served the Finnish nurses. No one who was at Helsingfors can ever forget the gracious and efficient manner with which

the Congress was organized, which did so much to ensure its success. Baroness Mannerheim did much in the critical post-war years to keep the Council together, and to keep united the nursing forces of Europe, when post-war conditions seemed tending toward a duplication of associations.

Of the nurses who began later to do international work, America has, of course, Miss Goodrich who was President of the Council from 1912 until the reorganization after the war; she is still one of its Honorary Presidents, elected as such, for her life, at the Helsingfors Congress. She was President during the critical war years, when nothing could be done, but she kept the organization together, and made it possible for threads to be picked up after the scarred years were over. Thanks to her there was an organization which could have a resurrection, as without her there might not have been.

Clara D. Noyes accomplished the difficult task of revision of the constitution between 1923 and 1925, to make it more suited to changing Twentieth Century needs. It was a hard and nerve-straining labor which has proved its worth by the ease of administration since the new constitution went into effect.

Sister Bergliot Larssen has done for Norwegian nurses a very great deal, and has contributed much to the International Council, including a sunny outlook which makes work easier. She believes it very necessary that a nurse shall take up her civic duties and advocates so modifying nursing education that she shall be prepared to undertake these responsibilities. Sister Bergliot shows how nursing touches all sides of life and how necessary, therefore, is that foundation principle of the Council, "the full development of the human being and the citizen in every nurse." She believes that with proper preparation nurses should make a very great social contribution.

Miss Reimann, our Secretary since 1922, who carries on the work at Headquarters, was born in Denmark. But she has studied and worked so much in Germany, England, and the United States (even having her degree of Master of Arts from Teachers College, Columbia University, New York) that she is really a cosmopolitan, and citizen of every country. She speaks several languages beside her own Danish more correctly than do the natives. Her clear and forceful mind has made many educational and government authorities recognize nursing as a valuable element in life and health preservation. Because of her efforts they are beginning to realize how much nursing can give toward national and international welfare, and to ask counsel from the International Council on some of these questions. Her journalistic and research contributions have already been mentioned.

To sketch every one of the people who have worked for and with the Council, and left their impress on our history, would take more space than the *Journal* could give us today. We have tried only to mention a few, to show how truly international is our group, and how much a world-wide organization can mean, as we have more people and funds to carry on our heartening privilege of working shoulder to shoulder to make the earth a better place in which to live.

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An Orchestra

RUTH M. KLOTZ, R.N.

IN the musical sections of the Sunday newspapers we find mention, favorable and otherwise, of many concerts presented throughout the country by well-known orchestras. We read of orchestral dramas to be produced in the Manhattan Opera House, of a Mozart Festival to be

ORCHESTRA OF GRANT HOSPITAL SCHOOL OF NURSING, COLUMBUS, OHIO

given in Harrisburg, Pennsylvania, and of many other musical events—professional and amateur, but we seldom read of a nurses' orchestra. However, a very successful nurses' orchestra is the proud boast of the Grant Hospital School of Nursing, Columbus, Ohio. Composed of student nurses, and organized November 15, 1927, this orchestra, under the capable direction of Oliver Grotefund, a Capitol University musician, has earned many laurels. Its first public appearance was during the Institute of Ohio State Nurses' Association, (November 7–12, 1927), at the Desh-ler-Wallick Hotel, Columbus, when in conjunction with the Nurses' Glee Club from the White Cross Hospital School of Nursing, and Mt. Carmel School, a delightful program was presented.

During the winter and spring months the orchestra has played a prominent part in many social affairs presented by the Grant nurses in their auditorium. One evening a week is devoted to rehearsals. The Dramatic Club of the student body and the orchestra, in March, gave a very clever presentation of "Savage-land," a musical comedy, under the direction of Catherine A. Page and Oliver Grotefund. The play was repeated by request.

The students and the faculty wonder how they ever got along without an orchestra, inasmuch as it has become such an essential part of their social and entertainment programs. They are not only able to play the modern jazz for the modern dance in a most "jazzy" and acceptable manner, but they are equally at home in a classical program. The continuance of this orchestra is most earnestly desired.

Dublin University Honored Miss Huxley

MARGARET HUXLEY, R.G.N., F.B.C.N. who received from Dublin University the honorary degree of Master of Arts, in June of last year, was trained and certificated at St. Bartholomew's Hospital, London. In 1884 she was appointed matron of Sir Patrick Dun's Hospital in Dublin where she worked for eighteen years. When she left this hospital her nurses wished to make her a presentation. She declined to accept anything for herself but asked that the money subscribed should be used to endow a medal. This was done, and the Huxley Medal is now awarded every two years to the best all-round nurse, and is a much coveted decoration.

In conjunction with Dr. Richard Hayes and others, Miss Huxley founded the Technical School for Nurses in Dublin, a central school to which all hospitals are invited to send their probationers for lectures to supplement the practical training given in the hospitals. The work of this school goes on, gaining in numbers and usefulness each year, and is still guided by Miss Huxley's wise counsels and sound judgment.

During all these years the Nurses' Registration Act was being considered and Miss Huxley can be regarded as the pioneer of the movement in Ireland. She was placed by the Government on the first Council and worked hard in framing the constitution and rules which now govern the registration of nurses.

As one of the foundation members of the International Council of Nurses, she is well known and has missed few of the international meetings.

An Englishwoman without any ties of family in Ireland, she has thrown in her lot with the country of her adoption, and her many schemes for the public good have kept people of divergent views together in the nursing profession. Miss Huxley is interested in civic affairs and has concerned herself in a successful housing scheme. The honorary degree of M.A. of the University of Dublin is an unusual and rare distinction and Irish nurses are justly proud that it should be bestowed on a member of the profession.—From *The I. C. N.*, April, 1928.

Cleft Lips and Cleft Palates

As Treated at the Children's Orthopedic Hospital, Seattle

HERBERT E. COE, M.D., AND VIRGINIA BOYER, B.S., R.N.

Causes

FOR many years we have had babies born with cleft lips and palates, but it is only rather recently that surgeons and nurses, working together, have been able to repair these deformities with such marvelous results that the average person scarcely notices the malformation. In considering this important branch of orthopedic surgery, the nurse should first be interested in the cause of such deformities. In the embryo, the three segments of the lip and the two sides of the palate unite at about the sixth to the tenth weeks of fetal life. Thus the lack of union of either the lip or palate or both is a developmental defect occurring during the sixth to tenth weeks of pregnancy. What causes this developmental defect? There are various possible causes but the most probable is *mal-nourishment of the mother* during those weeks. Out of some two to three hundred cases at the Children's Orthopedic Hospital in Seattle, two-thirds give a definite history of something that interfered sufficiently with the mother's nutrition to be a distinct causative factor—something more than the ordinary vomiting of pregnancy. One woman was frightened by the burning of her home, another was beaten frequently by her husband who did not wish a child, another was panic stricken with fear, night after night, at being left alone because her husband worked at that time, another kept unusually late hours running to dances and other amusements, and several had some acute illness, as influenza or pneumonia, during those weeks. All of these mothers were exceedingly mal-nourished during the sixth to tenth weeks of pregnancy probably because of the above reasons.

As to *inheritance*, only two to three per cent of the cases gave a history of like deformities in the family. Syphilis can only be suggested as a cause in two per cent of cases, which is not any larger per cent of cases than you would find in any group of pregnant women. Mothers may also be assured that there is absolutely nothing in the superstition of "marking." It is generally found that the terrible sight seen by the mother occurred at about the sixth month or so—at any rate at some time other than that in which these structures were uniting.

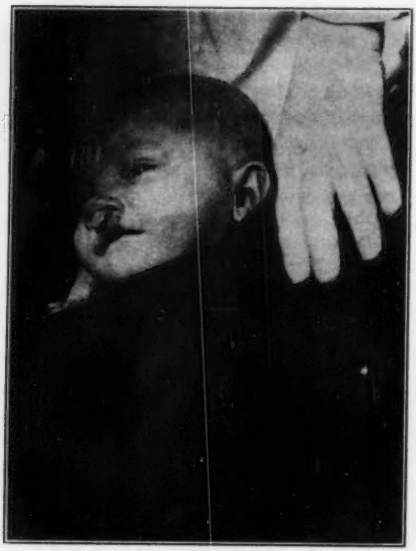
Is there necessarily a low intelligence quotient in cleft-palate cases? There certainly is, sometimes, but not necessarily so. Cleft lips and palates are a developmental defect; often more than one developmental defect occurs in the same child and the other might easily be a defect of the brain structure.

Care from Birth until Operation

THE fundamental principle in the *feeding* of cleft-lip and palate babies, from the time of birth until operation, is to maintain as high a state of nutrition as possible. This can be done by the use of orange juice, tomato juice, cereals, vegetable purées, cod-liver oil, and other vitamin- and iron-containing foods. The child must never be allowed to nurse at the breast or from a bottle, unless with a special cleft-palate nipple with a flap

above the nipple to fit across the cleft. The best methods of feeding are by Breck feeder, medicine dropper, or spoon. The mother should manually express her breast milk, regularly and thoroughly, and feed this to the baby. It is the best possible food.

Another important detail in the



DANNY HULST, AUGUST 24, 1926

care is the *strapping together of the lip with adhesive tape.* This should be done tightly enough so that the lip slightly overlaps. (We use a very narrow strip under the nose and widen it out on the cheeks.) This strapping tends to give a normal stimulation to the prolabium. The fact that muscles are attached to it in the normal child acts as stimulation to growth but, especially in a bilateral cleft, this stimulation must be furnished by artificial means. As an additional effect the nostrils are held together and prevented from widening too greatly.

Importance of Early Operation

IT is very important that all nurses, especially public health nurses, should recognize the importance of early operation. Unfortunately, to judge by the age of the children sometimes brought into our clinic, many parents, and perhaps some nurses and physicians, do not realize this need. An arbitrary weight of twelve pounds is set in the work here. This weight may occur at any time from two to ten months. It is chosen because it generally means that the child is gaining in weight steadily and consistently, he has become adjusted to his food and other stimuli, can stand a brief starvation period, and, of most importance, has not started any speech habits. The palate should be united before any faulty speech habits are formed.

The Necessity of Successive Operations: How Nursing Care May Lessen the Number and Shorten the Interval

THE cleft lip is generally repaired first, for two reasons: 1. It is most important to get the muscles of the lip to developing as soon as possible. 2. The improvement of the child's appearance has a good mental effect upon the parents and everyone concerned.

The cleft palate is then repaired and several operations generally are necessary. The nursing care is extremely important in this, as poor care can ruin the best of surgery. If the child is kept quiet, at absolute rest for five days, and if the palate is kept clean, the operation will be much more successful and less repair will be required in successive operations. The interval between operations depends to a large extent upon operative recovery. The hemoglobin may be

increased by giving sun baths, using ultra-violet rays, cod-liver oil, and other tonic measures. The feeding should be pushed—a little above the normal requirement should be given.

Immediate Pre-operative Routine

THE blood count, urinalysis, and other laboratory findings are important as for any operation. No cathartics are given, but an enema is given, not less than four hours before operation, if the child has had no dejection for eighteen hours. The pre-operative hypodermic is given at least one-half hour before operation. Atropine is always used, because the anesthetist's task is thus made easier. Morphine sulphate is not given to very small infants, but is used for older children and the unusually nervous.

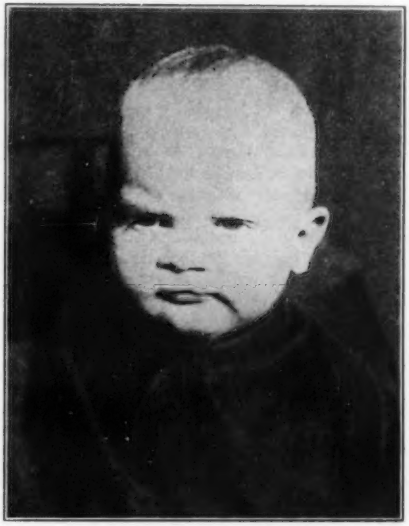
Post-operative Nursing Routine

THIS is perhaps the most important part of all to nurses, and the thing we wish to emphasize in this paper. At the Children's Orthopedic Hospital there is a definite nursing routine for these cases. Much of the success of the operation depends upon the care given by the nurse.

1. As to the general nursing care, the first thing of importance is that the child be kept quiet. It is extremely important that he should not cry at all for the first forty-eight hours. He should be kept quiet by being made as comfortable as possible. Special attention should be paid to wet diapers, the position, ventilation, and glare of lights, for the baby cannot tell what is bothering him. Morphine and chloral hydrate are to be given immediately upon return from the surgery, the dosage to be ordered. Chloral hydrate is then given by bowel every four hours in five per cent glucose solution.

2. The second thing of importance in the general nursing care is the constant wearing of cuffs on the elbows. This prevents the child from getting his hand to his lip to scratch the sutures in cleft-lip operations and prevents the sucking of thumbs or fingers which would be very detrimental in either operation. We make our cuffs of flannelette, stitched in sections so that tongue blades may be slipped in for support and be easily removed for washing of the cuffs. Several pairs of tapes hold the cuff around the arm and the shirt sleeve is pinned back over the cuff a bit so that it will not slip off. The cuffs are from five to seven inches long and three to five inches wide.

3. The care of elimination and dejections is important as in all post-operative cases.



DANNY HULST, APRIL 4, 1927

4. The feeding care is also of great importance. The child is never fed with a nipple, but with a Breck feeder, medicine dropper, or teaspoon. Feed something every two hours, until the fifth post-operative day, but do not awaken for feedings. The food should be specially prepared, sterile liquids. Non-coagulable ones should be used, as there should be no coagulation in the stitches. Thus no milk is used. Another reason for not using milk is that it is an ideal culture medium for bacteria, especially of the fermentation and gas-producing types. We give orangeade and grape juice, prepared as follows: *Orangeade*—16 oz. orange juice, 8 oz. water, 8 oz. white Karo. Boil water and Karo in a sterile pan, add orange juice, strain through sterile gauze, and bottle in sterile containers. *Grape juice*—10 oz. grape juice, 10 oz. water, 4 oz. white

Karo, 2 teaspoons gelatin, 2 egg whites. Boil water and Karo, add grape juice and gelatin, and when cold add the whites of egg slightly beaten. At the child's bedside the liquids are kept in sterile glasses, covered by sterile dressings held over the glass by a narrow strip of adhesive tape.

5. Follow each feeding with two drams of sterile water. Give twenty minims of milk of magnesia twice a day without water. The purpose of this is to insure an alkaline medium in the mouth and keep down acid-forming bacteria.

6. Beginning on the fourth post-operative day, small infants are given a modified cow's milk formula (mother's milk if possible). A very soft diet, including milk, is given to the older child.

7. Besides the liquids by mouth, fluids are given by bowel, four ounces, if it is possible to retain them, every time chloral hydrate is given. Fluids should be given every hour, from immediately after the operation until the child is taking fluids well. This is important to prevent dehydration. Occasionally two drams of Liquid Peptonoids are given in saline solution by bowel, every four hours, although it is rather doubtful as to the absorption of food from the large intestine. This is tried, however, in cases where it is difficult to give enough food by mouth and at least it has the value of a fluid.

8. Oral irrigations are begun on the fifth post-operative day. The purpose of these is to remove all particles of food from the wound, thus keeping the sutures clean and avoiding any infection. Warm saturated boric solution, sterile water, or saline may be used. The irrigation is given twice daily (or three times if necessary) one-half hour after meals, so the child will not vomit. Occasionally the irrigations may be omitted if the child is particularly upset by them, causing nausea and vomiting. In this case the sterile water should be continued after feedings. Sometimes a cotton applicator may be used with greater success than the usual method of irrigation with a rubber bulb syringe. We generally find it quickest and easiest to pin the child in a diaper or sheet, to restrain the arms, and lay him on a table with his head near a sink or emesis basin. By working very quickly, the treatment is over before the child has had a chance to become excited. The milk of magnesia is continued as in the first four post-operative days.

9. There is some special care necessary in cleft-lip operations. A steel traction bow attached to adhesive straps is applied in the surgery to act as a protection. On return to the room the wound must be kept absolutely dry of serum and blood coagulation even if a nurse must constantly be there to touch every drop of serum with a sterile cotton applicator. This is especially important for the first thirty-six hours. If the healing starts with a minimum amount of dead material, the scar will have a much better appearance. After each feeding the lip must be cleansed with applicators dipped in boric solution, both external and internal to the lip. Intermittent hot boric compresses are frequently used to produce a hyperemia. The bringing of good blood to the part promotes healing. Plugs saturated in compound tincture of benzoin are kept in both nostrils for the first forty-eight hours or so, to prevent vomitus from coming out through the nostrils and passing over the lip.

Removal of Sutures

THE sutures in cleft lips are removed by the physician on the second to the fifth day—the deep ones on the fourteenth day. Those in cleft palates are removed on the fourteenth day. The nurse should have ready sterile instruments, including stitch scissors, wire scissors, and forceps. She also needs applicators, sponges, boric solution and a mouth gag.

Resultant Speech Defects and Their Correction

THE speech defects are caused by injury to the soft palate. (1) The muscle development may be interfered with. The muscles may be atrophic and have never been together. Also, the stretching, during operation (the muscles are not cut, but stretched) paralyzes the muscle temporarily. The child then has to learn to use those muscles over again. (2) The soft palate is frequently short and does not reach the back of the throat. The child cannot then say certain sounds, such as k, hard g, b, and others. These sounds require closure of the throat by the soft palate. The child compensates for this shortness of

palate by developing the superior constrictor muscle of the pharynx. This draws a shelf of muscle tissue forward from the back of the throat to meet the soft palate and the child can then speak more distinctly. However, there is almost always some speech defect. The mother or nurse can do much in training the child to speak. She must always insist on the child's speaking plainly and distinctly, and insist on the easy sounds first. L, m, and the vowels are used, forming words such as mama. From these the child should gradually go on to words which require slightly more difficult sounds such as kitty; and from these gradually to the most difficult sounds.

It is very valuable to teach the child to sing, as this develops certain throat muscles. The use of the ones most easily controlled is learned first. At present the Cornish School, a private school of music, is trying to find some one to do special work with these children. It must be a person familiar with the principles of phonetics and one who understands what muscles must be developed.

Adenoids enable the child to speak properly as they tend to fill in the space behind the soft palate. They are thus not removed unless very badly infected. Tonsils, however, if at all enlarged, interfere with speech by pressure on the pillars and palate, and it is thus advisable to remove them.

Nursing Care of Harelip and Cleft Palate

As Practised at the Boston Children's Hospital

MARION BURNS, R.N.

TOO much stress cannot be placed on the nursing care of harelip and cleft palate. Gentle handling, cleanliness and thoroughness are important factors.

At the Children's Hospital, Boston, the following method is the rule.

Care of Harelip

THE optional age for operation on a harelip is three weeks to three months. In addition, the baby should weigh about ten pounds, and be gaining on a formula which will be given him after the operation. He is fed in the same manner before operation as after—that is, with an Asepto syringe, the tip of which has been protected with a piece of rubber tubing 2 inches long. The mouth and edges of the cleft should be clean and healthy, and the child should be free from an upper respiratory infection—such as bronchitis, rhinitis, coryza, etc.

The pre-operative care of a child under two years consists of substituting orange juice and water, equal parts, equivalent to the amount of the formula, for the early morning feeding on the day of the operation. A soapsuds enema is given three hours before the child goes to the operating room. Morphia and atropine are given immediately before the child goes to the operating room. If the child is between two and five years of age, glucose gr. v is given; if over five years, he is given glucose gr. x, 4 hours and 15 minutes before operation; and orange juice or clear broth four hours before operation. No preparation is done on mouth or lip; except to see that they are clean.

Post-operative Care

AFTER the operation is finished, the surgeon or his assistant adjusts a Logan clip to the face, so that the lip is puckered under the clip, which is held in position by a broad adhesive strap fastened to either cheek.

On return to the ward, the child is put in a warm bed and sheltered from draughts with a screen. Cuffs are put on over the shirt and the sleeve is turned back and pinned to the cuff to keep it in place. In cool weather, the baby is wrapped in a blanket—and care should be taken to see that the blanket is pinned tightly over the chest so that the baby cannot bury his face in its folds. In making the bed, the top covers should be tucked in place well below the axilla so that the child cannot brush his face against them. In warm weather, the child can be wrapped in a draw sheet—or any piece of cotton material; or the hands may be tied to the side of the bed. Cuffs are usually sufficient for children over two years. The child must be kept quiet and morphine is given every four hours p. r. n. For a baby of 3 weeks to 3 months, gr. 1/96–1/72 s. c. is usually ordered.

Feeding

ON the day of operation, the regular feeding due after the return from the operating room is omitted, and 4 hours later the formula is given. It may be diluted equally with water, and the baby is fed only as much as he seems to want. In the meantime, sterile water, 1 oz., is given, but not forced. Thereafter the amount of formula, as ordered, is given at four-hour intervals, and the baby usually takes it very well and retains it. Babies under two years seldom have nausea and vomiting.

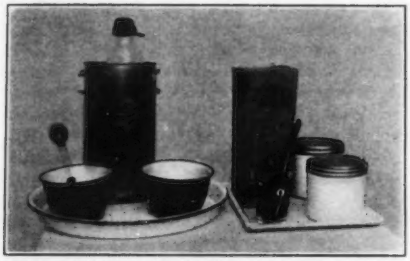
If the child is over two years, fluids without milk are given, as tolerated, the day of operation. On the day after operation, milk can be given, if tolerated, and the following day very soft food—such as gruel, creamed thick soups, finely mashed and strained vegetables, custard, junket or ice cream can be given.

In feeding the baby, this method is followed: Prepare a tray containing a sterile jar of 2 per cent boric acid, a sterile jar of harelip sponges, a plastic forcep in a glass of 70 per cent alcohol, and a paper bag. This tray is kept on the patient's table from the day of operation until after the wire is removed; and should be put in order every morning.

When the feeding is due, the bottle containing the formula is placed in an individual metal bottle warmer (which has been filled with warm water); a sterile cup with sterile water, a sterile harelip feeder, and an empty sterile cup (to be used for formula) are put on a tray and carried to the bedside. As the feeding must be given very slowly, a small quantity of the formula is poured into the empty sterile cup, and the rest is kept warm in the container. The child, during the first forty-eight hours, can be fed in bed; later, he can be picked up and held in a sitting position. Sterile water—about five drams—is given with the sterile feeder. After the formula has been fed, the harelip feeder is rinsed by drawing up several syringefuls of sterile water and expelling it into the cup that was used for the milk. The baby is again given about 5 drams of sterile water. With the forceps, the nurse picks up a harelip sponge and dips it in the boric acid solution; then swabs the suture line of the lip taking care not to catch the sponge in any of the sutures, and discarding the sponge in the paper bag after it has been used once. The lip is wiped with a dry sterile sponge until

it is thoroughly dry. If the baby regurgitates through the nostrils over the sutures between feedings, the lip must be cleaned in the manner described above. The important factor now is strict adherence to detail and the lip must be kept clean and dry all the time. If it is necessary to clean the nares, a tip of a harelip sponge held by the forcep is usually sufficient; although a sterile toothpick swab can be used. If crusts have formed from oozing serum, they can be softened by gentle swabbing with a boric acid solution sponge. They should never be rubbed or picked off.

In feeding a soft diet, a sterile spoon is used, and the food is placed on a dish that has been boiled. Sterile water is given a.c. and p.c., and the lip is cleaned in the above method.



Tray (left) used in feeding and tray (right) used when cleansing hare lip

To make a harelip sponge, a piece of gauze three inches square is folded in a triangle. The wide end is wound around the small finger—and the tapering end is rolled on itself to include all raw edges and is turned inside the wide end.

Removal of Sutures

IF the nostril has been held with a black silk suture, fastened with shot, the shots are removed on the fourth to fifth day or when they begin to cut into the skin. The spot is touched with alcohol and thereafter kept clean and dry. Alternate superficial stitches are removed on the fifth to sixth day, and the remaining sutures are taken out under ether on the eighth day. The Logan clip is removed at this time. The wire is usually removed on the tenth to twelfth day, and sterile technic is discontinued when this has been done. The baby is usually discharged two weeks after operation—and the cuffs are removed when the child is being dressed to go home. The mother is given detailed instructions with regard to feeding the baby. If the mother has an ample supply of breast milk—and if the baby's lip is completely healed, the mother is allowed to nurse the baby. If a formula must be given, a nipple is used. If the baby had a double cleft, and only one side was repaired, it may be necessary for the mother to use a harelip feeder at home, until the baby is returned to the hospital in two or three months' time for further plastic surgery.

Care of a Cleft Palate

Age.—The age of option is eighteen months to two years, preferably before the child begins to talk.

Pre-operative Care.—The mouth should be clean and healthy and the child free from upper respiratory infections. The immediate pre-operative care is the same as described for the harelip of two years or older.

Post-operative Care.—On return to the ward, the child is kept warm and quiet. Hemorrhage should be watched for and reported immediately. Cuffs are placed on the child and, if necessary, the hands are tied with bandage to the side of the bed, but after the first 24 hours this extra restraint is not required. Morphia is given for restlessness and crying, as the child must be kept absolutely quiet. The child is kept in bed until

discharged. All nourishment is given in a sterile cup; and is fed with a sterile spoon, the side of the spoon being placed between the lips. Fluids without milk are given until the fifth post-operative day. These include strained soups, broths, strained fruit juices, and malted milk made with water. On the fifth post-operative day, milk is given *ad lib.* Give sterile water, about 15 to 30 c.c., a.c. and p.c., to flush the mouth.

If the child refuses to take fluids with a spoon, a harelip feeder is used. Care is taken to see that the tip is well covered with rubber tip, in order to protect the child in case he should bite the feeder.

Sutures are usually removed on the eighth post-operative day under ether. About twelve hours afterwards, the child is fed soft diet and sterile technic is discontinued. On discharge, the mother is instructed not to give the child crusty foods, hard candies, nor to allow him to put any kind of objects in the mouth.

No treatment is given the mouth after operation, except the flushing with sterile water a.c. and p.c. The surgeon does not insist on examining the mouth, if the child objects; nor is a tongue blade ever used to force the mouth open, if the child refuses to open his mouth voluntarily.

The Healthy Woman at Forty

BY an artificial menopause, either surgical or X-ray, years of incapacitating ailments due to hemorrhage, the cause of the proverbial ill health of this period, can be averted and, incidentally, periodic headaches are often cured. As one woman expressed it, from being "puny" she became healthy and able to earn her own living.

To my knowledge, no one has taken on excessive weight from this treatment, developed arthritis, or lost any of her femininity, as prophesied by alarmists.

Fair, fat, and forty, is a desirable achievement gained by many women. However, for others it is a critical time. In modern civilization there is no place for mid-Victorian semi-invalidism. The handicap to business women and the economic loss of prolonged ill feelings at forty make relief imperative. A complete physical examination is important. Autopsies reveal that 40 per cent of women over forty years of age have uterine fibroids, one great cause of sterility. The tendency of such tumors is to bleed and to prolong the menopause, possibly into the fifties. Flashes may be said to be the only normal discomfort attending this age.

Tradition has surrounded this period in women with an atmosphere of mystery and superstition and taught them to look upon the climacteric with foreboding. They have learned to think of it in terms of disease rather than in terms of health. In the past they have been told that their trouble was physiological rather than pathological and would disappear in time. Through this policy of delay, women have suppressed their symptoms and have accepted the edict, "What can't be cured must be endured," and many curable conditions have been neglected. The old sophistries contain the danger of half truths, for although the symptoms may cease in time, as predicted, the constitution has been undermined and the foundation laid for early aging. There have been thousands of years of dark ages for women; in fact, near the close of the child-bearing age, they have always been martyrs to diseases that cause depleting hemorrhages, with resulting anemia, nervous exhaustion, and fatigue.

Radio-therapy is epoch-making, it is practically devoid of danger, and for the treatment of persistent hemorrhage, in suitable cases, it is one of the great boons modern science has brought to women.—From an article by Marion Craig Potter, M.D., prepared under the direction of the Gorgas Memorial, as part of its Better Health and Longer Life program.

Nursing in a Rural Community in Missouri[1]

MARY E. STEBBINS, R.N.

CERTAIN basic and fundamental problems are more or less common to all rural communities, probably, and just as probably each geographical area has enough definite local situations to produce conditions peculiar to that especial territory. It is for that reason that I beg your indulgence in limiting the discussion to Missouri rural communities and presume to do so as I imagine we, in Missouri, are involved in and are endeavoring to solve some of the particular problems with which we are faced here.

Shall we consider the matter under the following headings?

The present nursing situation.
Rural Missouri communities.
Outlook for nursing service in rural Missouri communities.
The nurse for a rural Missouri community.

The Present Nursing Situation

SO much has been said and written, recently, about the congestion of idle or partially employed nurses in the cities, the Grading Committee has made such a splendid and concrete contribution to our knowledge on the subject, the *Journals* have carried such enlightening articles, editorials and reports on the whole situation—its background, causes, present status, probable outlook and possible solution—that it would be a waste of time for me to repeat it here. We all know that there are vast numbers of nurses fully qualified to do bedside nursing who are complaining of the lack of employment in cities, who are fearful of the large classes of Freshman students being admitted each year into the schools of nursing, who are loath to go out of the cities (many of their arguments are pretty sound, too), and whose economic status frequently does not ensure happy, contented living—that "joy of life" which every one deserves and is justified in expecting; and that the schools of nursing are annually releasing increasingly larger and larger numbers of new graduates who are going into this already overcrowded field.

Of Missouri's 114 counties, twelve have full-time county Health Units. Of these, seven have one nurse on the staff, two have three nurses, two have four nurses and one has five nurses. Of the above, some of the nurses are working in affiliation with the Health Units, part or all of the funds being provided by one or more volunteer health agencies. Six additional counties are served by full-time nurses under other than official auspices, various volunteer agencies supporting them, as Red Cross, tuberculosis associations, Women's Auxiliary of the Missouri Medical Association, Kiwanis, etc. In all, eighteen counties have one or more full-time nurses doing county work. Twenty-five other nurses are serving in various capacities and in a limited area, such as a town, combining school and community work, or doing school work exclusively, the funds being provided in various ways. The Metropolitan Life Insurance Company partially or entirely supports eight of these; P. T. A. funds, school funds, community funds, Red Cross funds, tuberculosis association funds, etc., are contributed in varying amounts and proportions, with the possibility that other volunteer agencies, such as

[1] Read at the annual meeting of the Missouri State Nurses' Association, Springfield, October, 1928.

business men's organizations, are also contributing.

The programs of such nurses are largely educational, and rightfully so, for they endeavor to prevent health casualties rather than wait for the "end-results" of sickness—mental, moral and physical dependency, decrepitude and death. This is a wise investment of time, energy and money, and is to be encouraged. What percentage of the time of such nurses is given to bedside care I cannot state; probably exclusive of the M. L. I. nurses, only emergency work, if any, and that necessarily kept down to the minimum. The M. L. I. service includes visiting bedside nursing for the company's policyholders.

The number of nurses living in rural districts and systematically doing bedside nursing for pay is probably negligible. I have been unable to ascertain how many may be so engaged. An occasional married nurse is known to be giving of her time and skill without pay, for the benefit of her neighbors near and far.

When we have accounted for all the nursing resources of the rural areas we are still faced with a deplorable lack, almost entire absence, of qualified nursing service for bedside care, outside the cities. Places that can be reached in two or three hours by bus or train are not infrequently faced with the fact that idle nurses in the city refuse their calls or, if they do accept the call, find some reason why they must leave the case and return to the city; that almost the entire rural area is dependent upon the neighbors in case of sickness, upon untrained care for hire, or upon their own struggling efforts; and that over 90 per cent of the cases, we are told, are cared for in the homes.

We are informed that a relatively high percentage of sickness occurs in the country as compared with the cities; country children, for instance, the New York Commission on Ventilation tells us, have more colds than city children; the epidemics of contagious diseases are proportionately more severe from two standpoints: first, the percentage of the population involved—as, when mumps invaded one community, practically every family contracted it with as high as 100 per cent of cases in many families; and second, in the seriousness of the individual cases. The percentage of the chronically ill in the home, the permanent "sick-a-beds," is high. The percentage of deaths is high as compared with the urban rate. One town of less than 100 inhabitants had a funeral a day, for six successive days, and it was not an epidemic situation; two were babies who had died of some intestinal condition, vaguely diagnosed, one an appendix case, unoperated upon, and so on. A town of 915 inhabitants had, in October, 1928, five deaths in one day.

While the present status of morbidity and mortality reporting is an improvement over that of a few years ago and while the efforts to further improve it are being continued, still the available figures do not present the actual situation relative to sickness and disease in the rural districts of Missouri. We know full well, relative to tuberculosis, that hundreds of death certificates are presented for cases that have never been reported, though tuberculosis is a reportable disease. We suspect, too, that many more death certificates show the deaths due to some other cause than to tuberculosis. One woman who had been discharged from the State Sanitarium for Tuberculosis at Mount Vernon, as a hopeless case, died a short time afterward. The death certificate read "Intestinal Poisoning."

Summary

WE have, then, cities overcrowded with unemployed, or partially employed qualified nurses, the rural sections almost entirely without qualified nursing service in spite of the fact that the percentage of sickness and deaths is proportionately higher in the rural than in the urban districts.

With a big need for nursing service on the one hand, and an oversupply of nurses on the other, it would seem that both problems could be simultaneously solved if a means were provided by which nursing in the rural districts would become attractive to nurses and if such nursing service were within the financial reach of the rural dwellers.

Rural Missouri Communities

THERE is no question about what is or is not officially "rural." The U. S. Census Bureau has settled that for us by including in the rural population all those living in the open country and in towns up to, and including, 2,500 inhabitants. Under this ruling over half Missouri's population is rural. Many of the towns having more than 2,500 inhabitants, some of them very many more, are found to have problems identical with the smaller towns and the open country: these could well be classed as rural and so considered. Under that classification a much higher proportion of Missouri's people would be included in the rural population. . . .

How, then, do we decide what constitutes a rural community in Missouri? Definite organization of Rural Community Associations has been carried on by the Community Organization Specialist of the Missouri College of Agriculture, utilizing certain well-known principles, but adapted to our own situation, in roughly mapping out such communities. A logical center, a village or a town, and its surrounding open country, including all its little neighborhood groups, is considered, keeping in mind always that people will go where they wish to and should, but that those living within a reasonable distance will have a tendency to utilize the facilities at hand. The size is, therefore, determined indefinitely by the general trend and drift of those whose human interests as trading, church affiliations, telephone central, if there is one, school opportunities, etc., naturally take them to that center. Roads, their direction and condition, are a definite determining factor. It is sometimes necessary for certain persons to go many more miles to some other place, just because there is no road to the nearest and logical village, or its upkeep is so inferior that it is in a condition to be used in the most favorable weather only. Sometimes, too, the "creeks are up," and that is a tremendously limiting factor in large sections. Some of them will "run down" in a few hours, in which case one waits on the bank and watches the waters recede until low enough to permit fording; in other cases, as in the rainy seasons, one may be entirely cut off for days. Sometimes the bridges "are out," even where bridges have been; a sudden mountain downpour, with all the water rushing down all the surrounding hills at the same time, overwhelms its meager strength and it follows the way of the weaker in any struggle. . . .

We find the term "community" often loosely used in a much more liberal sense, being interpreted to mean a group of people of any size or constituency, as a village, town, city or county, and to accept then the inference that such a community includes its surrounding area and its

many smaller groups. It simplifies thinking to refer to a county, as a county, leaving the word "community" to be used in its more generally accepted sense.

Rural communities, however the word is interpreted, have problems quite distinct from those found in urban territories or bordering urban territories; for instance, situations found in St. Louis or Jackson counties could not guide one's thinking in matters pertaining to an Ozark county where a man on one side of the river can hear sounds, indistinct voices, barking dogs, etc., from a neighbor's farm across the river, but he must drive, or walk, sixteen miles up the valley on his own side of the river, and back down the valley sixteen miles on the neighbor's side of the river, before they can meet. Your reaction may be: "Why not get a boat?" You have just never tried to negotiate that river, that's all. There are sections where the homes follow the valleys between the ranges of mountains, perhaps five or six families straggling miles up one valley, two or three, possibly, up another; no passes over the mountains; the only way to reach each other being to come clear out of one valley and down the other equally as far. One of our extension agents drove thirty-four miles from one man's farm to that of his nearest neighbor's "as the crow flies." Not being a bear, he couldn't "go over the mountain to see what he could see." Some of our counties are almost or entirely without railroad transportation.

Or consider the flat, cotton-growing counties of the southeastern part of the state, with their very definite and peculiar difficulties of absentee landlords and a dissatisfied, frequently changing tenantry on a one-year lease plan. Their psychology is altogether different from that of their land-owning, land-loving near neighbors of the hills. The mining districts present still another set of problems, racial and industrial. Again, think of the more thickly peopled, financially more favorably situated counties of middle and north Missouri, one such county having a population of 29,672 on 688 square miles of land. (Its largest town has a population a little over 10,000.) Compare this with the county of 655 square miles and a total population of 8,147. These northern counties, however, are still making many of their roads of dirt which, it seems, in spite of engineering arguments to the contrary, do inevitably dissolve into the slipperiest and stickiest of mud when the rains descend upon them. . . .

The truly rural county of whichever section will have a collective thinking based on the individual thinking of the families within its boundaries. The thinking of a scattered, isolated people cannot even approximate that of families in the more thickly settled areas. Life's problems are just too different. These isolated families have retained much of the self-reliance, independence and individualism of their forefathers; they have, by very force of circumstances, to depend upon themselves in all sorts of emergencies, as well as in all, or almost all, of the every-day occurrences of every-day life. They have become sturdy in so doing. Remember, too, that all of the life of the farmer and his family, wherever located, is one stern struggle against all odds, wind and weather, cold and heat, rains and droughts, insects and pests, and that one naturally develops the battling habit and a faith in one's own ability, when life itself is dependent upon one long, continuous, never-ceasing warfare. Since all of nature is against him and he is

determined to survive, he fights on and on in order not to succumb.

Of actual money there is little, pitifully little at times, but that fine, sturdy independence struggles along in an effort to have the best possible, but only that which can be paid for, and to go without the desired and the desirable when it can't. The fact that they have survived, that each generation has and is making progress, is proof enough of the fundamental rightness of them and their practices; if they are sometimes loath to take up newer ways in a hurry, should we blame them? They have some pretty good arguments, why they should not; but be sure that if there is any wisdom, or goodness, or worth or advantage in what is offered, if you have the patience to make that clear, and they are once convinced, they will thereafter just as obstinately adhere to the newer ways and will be ready for more. It is altogether to their credit, isn't it, that a thing must be proven before it can replace an age-old belief or habit or custom?

The town or village which is the center of the community will not differ greatly from the standards of the open country by which it is surrounded and upon which it is dependent for its very existence. A thriving town will be found in the midst of successful agriculture; unambitious towns or villages in less successful districts. Farm families who have left their farms and come into town to make their homes exert a very definite influence upon the town policies, usually conservative, sometimes ultra-conservative. A retired doctor and farmer, living in a mid-Missouri town some years ago, being exasperated because the vote had defeated the proposed water-system bonds, said to me: "We'll never have anything till the —— farmers, who have come to town, die." He had himself come from a farm, but he had come sooner and had changed some of his ideas about things.

You can see that those same farmers, now living in town, had survived to advanced age without a town water system, and hadn't found out yet that it was sufficiently desirable to be worth all those thousands of dollars, and dollars had always been very scarce and hard to get.

Another complication is presented by the attitude of the town and country folks toward each other. In such an overwhelming number of instances they don't get along with each other at all, and those animosities and jealousies have to be smoothed out or over before constructive work for or with the combined group can progress very far.

Rural communities, as urban communities, do have definite responsibilities whether accepted as responsibilities or not; they do have some opportunities to fulfill those obligations; such opportunities are not and will not be recognized until, or when, a group-consciousness is aroused. In the smaller towns and villages, and in many of the important and ambitious towns and small cities, group-consciousness is still in a nebulous state.

So we find our rural Missouri communities large in area, often handicapped by meager transportation facilities; financially struggling; having a center with an unawakened group-consciousness, barely stirring at the most; a surrounding open country peopled with more or less individualistically thinking and acting, self-reliant agriculturists; a divergence of thinking between the town and open-country people; and in certain limited sections of the state special racial and industrial problems.

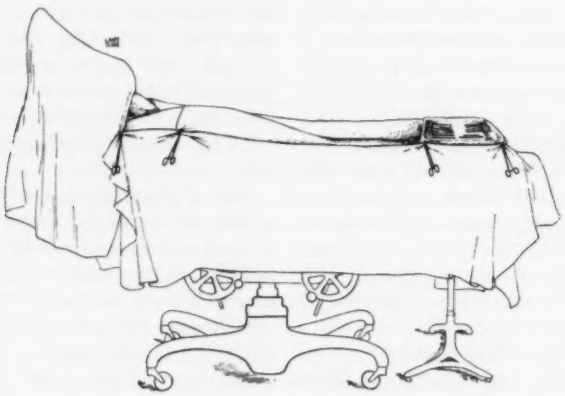
(To be continued)

On the Operating Table

Method of Clamping Sheets So That Instruments May Be Prevented from Falling[1]

FRANK H. LAHEY, M.D.

THE illustration accompanying this note graphically explains how, by clamping the sheet covering the table in goiter or neck operations, a trough-like arrangement can be obtained, so that instruments do not readily fall to the floor.



The Trendelenburg table is placed eight or ten inches higher than the patient's shins, over which it rests. The fold of the sterile sheet covering the patient is then fixed by hemostats to the sterile pocket cover over the Trendelenburg table, and the folded portion of the sheet is likewise clamped at the head of the table to the sheet, which is turned upward over the anesthetist's bar.

This forms a side wall of sheeting on each side of the patient's chest and abdomen, making a rectangular trough into which instruments and needles readily fall when placed on the patient's body in semi-reclining position.

This arrangement is described here in the hope that it may prove as valuable to other surgeons as it has in this clinic.

[1] From the *Journal of the American Medical Association*, October 13, 1928.

N. L. N. E. Dues

BY vote of the Board of Directors of the National League of Nursing Education, last June, the Treasurer's membership lists are now at Headquarters, and dues are receivable there. A busy Director of a School of Nursing should not be burdened by details of dues received, and such routine work can more easily be done at Headquarters.

In view, therefore, of the new and simplified method, will all individual members please send their dues directly to Headquarters in January, without waiting for a notice, thus saving time and postage?

If members of State Leagues will send their dues directly to the State Treasurer in January, she can then forward all at once to the National League, within the time limit of the by-laws.

Thoughtfulness and efficiency—good mottos for the new year.

The United States Veterans' Bureau Nursing Service

A Satisfactory Field of Endeavor for the Ambitious Nurse [1]

THYRA E. PEDERSEN, R.N.

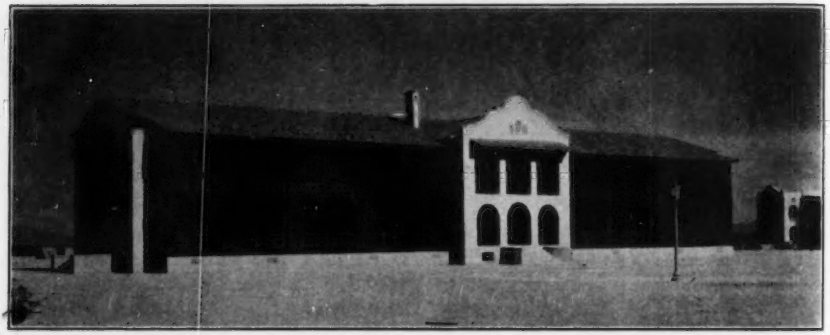
IT is sometimes charged that the various government services furnish little or no competition to their personnel and that without the incentive resulting from and opportunities produced by keen competition, many of even the more ambitious fall into the rut of intellectual stagnation. Those holding this view feel that the Government services are so constituted that ambitious employees do not find the field sufficiently broad or elastic for professional or technical development and that such services find it difficult to attract or hold employees possessing other than mediocre ability.

In no sense, however, is this true of the Nursing Service of the United States Veterans' Bureau, for here there is not only ample opportunity for self-improvement, but every incentive to put forth effort to advance in the profession.

In the early years, the nursing service of the United States Veterans' Bureau was not so well stabilized as was the case in many other lines of endeavor, due to post-war restlessness. Central Office from the outset, nevertheless, endeavored to develop a nursing corps that would render the most efficient service possible. Stabilization in these early years was, however, largely dependent upon the initiative and resourcefulness of the individual nurse and in the final analysis it could be effected only through her interest and enthusiasm. It was shortly discovered that endless ward routine was deadly, if there were no prospect for advancement and development; and if the best service was to be rendered, opportunities for reading and study outside of recreation hours would be required if the nurses were to keep pace with the new ideas constantly advanced in the medical and nursing world. Indeed, the progressive and successful nurse, like the successful business or professional man, finds it quite essential to be educated far beyond a mere working knowledge of her profession. The acquirement of such additional technical education in nursing is largely a matter of work in, study of, and daily association with advanced technical problems—problems entirely beyond the scope of the training school. It follows then that the hospital, the clinic, and the laboratory are the logical places in which to make contact with these advanced technical problems and to obtain instruction and help from the associated medical personnel in their solution.

In this connection it may be noted that the Veterans' Bureau has a large patient population which is undergoing diagnosis and treatment under the latest scientific methods. The laboratories are equipped to render the information necessary to obtain as accurate a diagnosis as is possible. The hospitals are also prepared to secure for the patient the treatment that will aid

[1] We have recently received notification of a new scale of salaries in this service. Nurses now entering receive $105 per month, plus quarters, subsistence and laundry. The living quarters are very good. Graduation from a four-year standard high school course is a requirement for entrance.—ED.



U. S. VETERANS' HOSPITAL, TUCSON, ARIZONA—NURSES' QUARTERS LOOKING SOUTHEAST.

in his recovery, if at all possible, and the regular medical staffs are supplemented by consultants of national reputation.

However, personal contact with technical problems is not alone sufficient. There must be also instruction, regular courses of study in connection with the work and, from time to time, special courses for selected groups.

Recognizing the soundness of these principles, the Veterans' Bureau has developed a forward-looking policy in the matter and has assumed the responsibility and expense of providing time, material and instruction that this policy might be most effective. Four postgraduate courses in Tuberculosis and Neuropsychiatry were organized by Central Office in 1922 and 1923, and both the nurses and the service in general were greatly benefited thereby. The following subjects were included and indicate the scope of the courses:

NEUROPSYCHIATRY

General:

General principles of psychiatry.
Concept of mental abnormality and general management of insane and neurotics.
Mental tests.
Observation and ward notes.
Brain pathology.
Mental hygiene.

Special Clinical—including Therapeutics:

Feeble-mindedness.
Endocrine and mental disorders.
Cerebrospinal syphilis.
Arteriosclerotic and senile psychosis.
Epilepsies.
Psychoneurosis.
Situation psychosis.
Dementia præcox.
Manic depressive psychosis.

Special Therapy:

Psychanalysis—meanings and methods.
Hydrotherapy.
Occupational therapy.
Tube feeding.
Principles of reëducation.

TUBERCULOSIS

I. Bacteriology:
  Tubercle bacillus.
II. Clinical Manifestations:
  Spinal tubercle.
  Tuberculosis in children.
  Apical infections.
  Adult infection.
  Complications.
III. Symptomatology:
  Physical signs.
  Sputum.
  X-ray.
IV. Special Treatment:
  Nursing technic.
  Physiotherapy.
  Follow-up care.
  Pneumothorax.
  Nursing early cases.
  Nursing advanced cases.
  Medical care of advanced cases.
  Diets.

U. S. VETERANS' HOSPITAL, TUCSON, ARIZONA—INFIRMARY LOOKING NORTHWEST

With a view to better preparation of nurses for neuropsychiatric work, the Veterans' Bureau contemplates organizing another postgraduate course directed especially to the development and application of methods in administrating psychotherapy and in promoting mental hygiene among the nervous and mentally ill. It often appears that in the neuropsychiatric hospitals, in both Government and civilian service, uneducated attendants are involved to a greater extent in the actual treatment of patients than are the nurses. The latter, being somewhat burdened with housekeeping and other tasks, are too often unable to study and observe the mental reactions of patients under their care or to effectively assist in the mental therapy. It is believed that the proposed course will remedy this situation in the Veterans' Bureau service.

Aside from postgraduate study, in every hospital there has been established a yearly course of lectures for nurses, the subjects of which have special reference to the type of patient hospitalized. These courses are conducted by the staff physicians and consultants and include among other topics:

TUBERCULOSIS

Tuberculous infection: Bacteriological and pathological conception of tuberculosis.
Characteristics of germ.
Methods of isolation and examination, X-ray.
Sources of infection: milk, meat, sputum excreta other than sputum.
Theories of invasion: inhalation, ingestion, inoculation.
Theories of resistance and immunity: racial, environmental, artificial.
Theories of childhood infection.
Types of disease at different stages: infants, children, adults.
Pulmonary: Anatomy; classification of stages—incipient, moderately active, inactive, etc.
Complications: Larynx, intestines, joints, hemorrhage, pleural effusion, spontaneous pneumothorax.
Tuberculosis: surgery.
Predisposing causes.
Early diagnosis.
Treatment: Fundamental factors—rest, food, fresh air, discipline.
Supplemental factors: Climate, exercise, therapy (P. T.) O. T.
Incidental factors: Drugs, etc., heliotherapy, physiotherapy.
Social aspects: Prophylaxis, social and economic factors, sanitary factors, control.
Education.
Legislation.
Work of the nurse in tuberculosis prophylaxis: Phthisophobia, hospital, clinic and dispensary, teaching, homes.
Industrial rehabilitation.

NEUROPSYCHIATRY

Evolution in man and the development of the conscious; ideation and affect.
The world of reality and human reactions; conditioned behavior.
The meaning of adequate and inadequate reactions; normal versus psychopathic behavior.
The development of the personality in the light of genetic and environmental stress; social adaptability.

Constitutional types of reaction to reality; schizoid and syntonic.
Affectively motivated complexes in the unconscious as etiological factors in behavior; phobias, fixed ideas, mental projections.
Schizoid reaction types; conversion syndromes motivated by the unconscious.
Schizophrenia: dementia praecox and paraphrenia.
Kraepelin's conception of dementia praecox—simple, hebephrenic, catatonic, paranoid.
Kraepelin's conception of manic-depressive psychoses; mood swings in syntonic types.
Psychopathic reactions to trauma, infections and endogenous or exogenous toxins.
The meaning of recovery from a psychosis; social adjustment versus adequacy.
The physiology of mentation; neurons; brain cortex, basal ganglia, and peripheral tracts.
Mental defect; effect on mentation and behavior.
The meaning of psychological measurements; educability versus social adequacy.
Psychometric technic—for the literate, for the illiterate; practical application.
Classification of mental defectives; consideration of etiology; heritable and acquired types; regression; deterioration.
Mental deficiency versus constitutional psychopathic inferiority; obligophrenia; affective deviation.
Psychoses resulting from organic destruction of neuron tissue; general paresis—cerebral type, tabetic type.
Encephalitis lethargica.
Psychoses with arteriosclerosis; aphasia, alexia, and organic paralyses.
Multiple sclerosis and other organic diseases of the brain and spinal cord.
Psychoses; abnormal behavior and the law.

The comment of one of the Clinical Directors of the Veterans' Bureau relative to the courses given at his station for the year is as follows:

The special postgraduate course of lectures on psychiatric nursing which will be given this year to graduate, registered nurses on duty at this hospital, covers the whole subject of psychiatry and social adequacy. Its scope and goal are the same as those sought for in the best clinics of the country and the method of approach is similar to collegiate courses on nursing given in conjunction with a course for a degree in science.

Many of the Veterans' Bureau hospitals have instituted the practice of permitting nurses to attend clinical staff conferences and one of the assistant chief nurses, referring to the educational advantages, states:

Within a few months after the opening of our hospital there was extended to the nurses the opportunity of attending the clinical staff conferences at this station.[2]

This, it is believed, has had a marked tendency to maintain interest and enthusiasm in their work, thus keeping up the morale so greatly to be desired. These conferences are held five days in the week. The case record is presented by the physician who examined the patient. The following information is included in the presentation of the case:

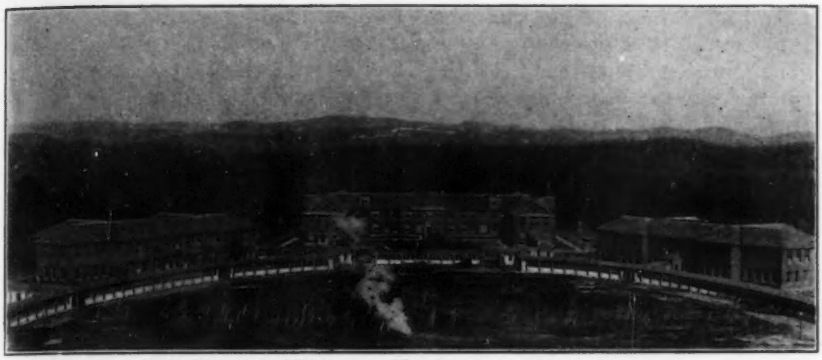
Family, personal, and military history.
Onset and course of the disease.
Physical and neurological findings.
Mental status.

The patient is then brought into the conference room and is questioned along the lines that would bring out his mental symptoms and abnormal states. After the patient has left the conference room, the diagnosis, treatment, and conditions of parole are discussed by members of the medical staff. These discussions are most interesting and helpful to the nurses, inasmuch as it gives them the different viewpoints expressed by the various physicians and their reasons for their conclusions. It also familiarizes the nurses with psychiatric nomenclature and gives them a better understanding of the patient's condition, thereby enabling them to deal more intelligently with the patient himself and aiding them in expressing their observations more clearly when writing progress notes. They learn, too, more about Bureau regulations, hospital routine, and other valuable information which is difficult to convey to them in any other way.

In conclusion, the opinion is advanced that in no other way can the nursing service be so intelligently improved with expenditure of so little time and effort as by the regular attendance of the nurses at these clinical staff conferences.

Attendance by nurses at post-mortem examinations has proven a most effective means of acquiring accurate knowledge of anatomy and pathology.

[2] Only those nurses involved in the care of the patient before the staff are permitted at the conference.



U. S. VETERANS' HOSPITAL, NORTHAMPTON, MASSACHUSETTS

Discussions of the individual cases by the doctors, the showing of X-ray plates, and comparing their findings with the original diagnosis, offer unlimited opportunities of learning more about tuberculosis in general and an individual patient's condition in particular than could possibly be learned by mere bedside nursing care.

Such combined training in both practice and theory increases the nurse's understanding and skill immeasurably and she at once feels a keener interest in the individual patient and is accordingly able to give him more intelligent care than would be possible without this background of knowledge and experience.

Furthermore, the thirty days' annual leave granted nurses of the Bureau creates a possible opportunity for them to attend the summer courses established for nurses in a number of the universities of the country.

The League of Nursing Education admits chief nurses and head nurses of the Veterans' Bureau into membership for the reason that chief and head nurses in the service act in the capacity of teachers of staff nurses and attendants. This teaching capacity qualifies them for membership, but as usual the teacher benefits more than the pupil in that the discussions and instructions sharpen their interest and demand deep and keen study.

The Veterans' Bureau, furthermore, has adopted a policy relative to the granting of official leave to nurses on its staff in order that they may attend the biennial conventions of the American Nurses' Association. Sixty-five Bureau nurses were present at the Convention in 1926.

The various stations of the Veterans' Bureau are equipped with comprehensive medical libraries containing the standard texts by the recognized authorities. In order to keep the medical libraries supplied with the most advanced and up-to-date information procurable, they are supplemented at least once and sometimes twice each year with the latest texts, and each hospital or clinic receives a generous supply of standard medical and nursing periodicals.

The fact that many of the stations are located in the vicinity of educational centers offers another splendid opportunity through which many ambitious nurses add to their professional education. The number of nurses who are taking advantage of this opportunity is constantly increasing, thus indicating the ever-growing desire

on the part of those engaged in nursing to excel in their profession.

The Nursing Department of the Veterans' Bureau offers many other advantages than those discussed herein, but the above suffice to show that nurses who are ambitious and alert may receive in their assignments in this service a training equal in value to one or more postgraduate courses. They will find in this service a wide and elastic field for the development of individual talent, and an opportunity for training and education probably not excelled in any other service or profession. Seldom does the ambitious nurse find an assignment equally advantageous.

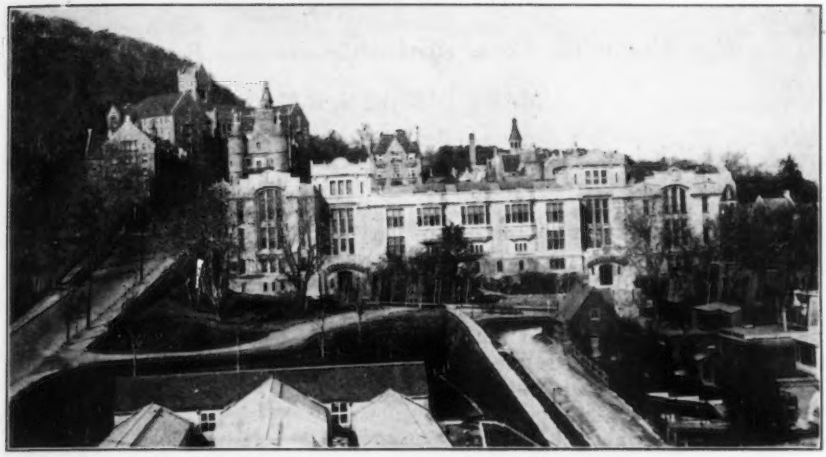
Nursing Education in Canadian Universities

ANNE SLATTERY, R.N.

SINCE 1920, when the first postgraduate course in Public Health Nursing was established at Dalhousie University, Halifax, a number of Canadian universities have established departments to provide for this need in the community.

ROYAL VICTORIA HOSPITAL AND MCGILL UNIVERSITY, MONTREAL

The School for Graduate Nurses at McGill University, from the beginning of the work in 1920, recognized the need for postgraduate work to prepare teachers and administrators for their work in schools of nursing as well as public health nurses. Four courses, therefore, have been offered: Teaching, Administration and Supervision in Schools of Nursing, and Public Health Nursing. In the near future



NEW MEDICAL BUILDING, McGILL UNIVERSITY, MONTREAL

this school is planning to establish an undergraduate course leading to a degree. This will be in connection with the local hospitals with which McGill University is very closely connected.

The University of Montreal has established a course in Public Health Nursing extending over one academic year. This course is planned for French students and the lectures are given in that language. It has been very valuable in enabling French public health nurses to be prepared for work in the province of Quebec. The Department of Public Health Nursing at Toronto University gives an outstanding course in Public Health Nursing. Two arrangements are possible—a postgraduate course of one year, or a two-year course consisting of one session's work before entering the School of Nursing at Toronto General Hospital and followed by the final year at the University, after the student completes her work in the Hospital School. In 1928 a course in Teaching and Administration in Schools of Nursing was added to the graduate work offered at the University.

Western University, London, Ontario, offers postgraduate courses of one year in Public Health Nursing, Hospital Administration and Teaching in Schools of Nursing. There is also a B.Sc. course in Nursing established at this University, which extends over five years.

The University of British Columbia in Vancouver offers a five-year professional course leading to a degree in connection with the Vancouver General Hospital School of Nursing. During the fifth year, when the student returns to the University, she selects a course in Public Health Nursing or Teaching and Supervision in Schools of Nursing.

The University of Alberta in Edmonton offers a course in Nursing extending over five years leading to the degree of B.Sc. in Nursing.

These courses are also open to graduate nurses of approved qualifications who desire a postgraduate course.

Details regarding the various courses outlined above may be found in an article in the *I. C. N.*, for July, 1927, "Nursing Education in Universities in Canada."

A Modified Croup Tent

For Use with Communicable-disease Patients[1]

MARY DINNEEN, R.N.

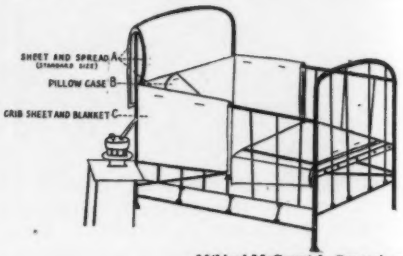
WHEN it is necessary, because of the nature of the disease, to provide individual equipment for the treatment of croup, the croup tent requiring a frame, used in most general hospitals, has been found impracticable. There are too many articles to become contaminated on a communicable-disease service, and there is not room for them in the cubicles. Their disinfection would require too much time, which should be devoted to the care of the patient.

To meet the need for a tent which would make possible the same results, and at the same time be practicable in hospitals for communicable diseases using the unit system of technic, a tent made of linen and blankets has been devised at the Willard Parker Hospital. This tent is both labor- and time-saving, because it may remain on the crib as long as the treatments are continued. Equipment needed:

1 standard size sheet
2 crib, or small, blankets
1 pillow-slip
1 croup kettle
1 standard size spread
2 crib, or small, sheets
16 medium safety pins

Procedure: The large sheet and spread are folded separately, in thirds, lengthwise. Then they are draped together over the head of the crib, allowing enough material inside the crib to tuck at least four inches under the mattress. The four-inch allowance is pinned at each side to the spring.

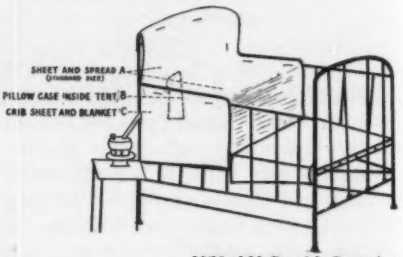
The sheet and spread are stretched to the top bar of the crib, and pinned on each side. This acts as a pad for the back of the crib, and makes the top of the tent which, when open, hangs loose over the back of the crib to approximately three inches above the floor.



Mildred McCormick, Supervisor

CROUP TENT (OPEN)

To make the sides of the tent, crib blankets are folded in half and are protected on both sides by crib sheets which are folded so as completely to cover the blankets. These are held securely by safety pins, placed at intervals below the bar of the crib. The sides are pinned securely to the back, and a small opening is left at one lower side, for the insertion of the spout of the croup kettle.



Mildred McCormick, Supervisor

CROUP TENT (CLOSED)

[1] The Willard Parker Hospital is the hospital of the Health Department which cares for communicable diseases in the Borough of Manhattan, New York City. It has a capacity of 400 beds, most of which are full between December and July, and uses individual isolation technic for its patients.

A standard-size pillow-slip, folded across once, then lengthwise, making four thicknesses, is pinned across the corner of the crib, where the opening is allowed for the insertion of the spout of the kettle. The hypothenuse of the triangle thus formed by the pillow-slip should be about two-thirds the height of the crib.

The top of the tent is then drawn over and pinned to the back, even with the sides. It is stretched to the end of the sides, and pinned. The extra length forms a flap which closes the tent. This flap hangs free, so that it may be easily lifted, and the patient watched during the treatment.

The pillow-slip protects the child from the steam, so that he can never be burned.

An Experiment in Group Nursing[1]

ETTA S. HALL, R.N.

TWO years ago the West Suburban Hospital of Oak Park, Illinois, found it necessary to make some provision for the patients who were too sick to be on floor care and who were unable to pay $17 per day for twenty-four hours of special nursing. Physicians found that these patients were able to pay a moderate amount and were very willing to do so.

The group-nursing plan, as worked out in Rochester, Minnesota, at St. Mary's Hospital, was studied by the Board of Directors, and it was decided to try a similar plan—not to aid the hospital financially, but to give efficient nursing care at a lower cost.

Our experiment is, on this date, two years old. It is a record of the care of between 450 and 500 cases, medical and surgical, men, women and children. It is a record of about 3,500 days of nursing care. The surgical cases include hysterectomies, gallbladders, prostatectomies, thyroids and some tonsils; the medical cases include pyelitis, cystitis, gastric ulcers, pneumonias and a number of accident cases, mostly fractures.

The plan we have worked out is as follows: One floor of our new addition is set aside for this experiment. It has a supervisor's office with adequate space for charting, for drugs, linen, sterile and other supplies. There is a janitor's closet, and a utility room with ice box, gas stove, hot and cold water sterilizers, linen and trash chutes. There are eighteen private rooms in the section, each with a Ford adjustable and coil spring mattress. Each room has a clothes closet and a private toilet room, the latter having a built-in metal cabinet with a complete set of sick-room utensils which make it possible for the nurse to give a bath, enema or alcohol rub without leaving the room. This saves much time and many steps for her. The patient appreciates the individual equipment and the time thus saved, running for things, can be used in caring for the patients. The fact that each patient has a private room makes our plan a little different from that of other hospitals.

For this eighteen-room section, twelve nurses are employed by the hospital. They receive $125 a month, board and laundry, but no room. They work eight hours a day, with one day off a week. Eight nurses are on day duty, two on night duty, and

[1] Read at the annual meeting of the Illinois State Association of Graduate Nurses, Joliet, Ill., October 18, 1928.

two on relief. The relief nurses work from three o'clock in the afternoon until eleven at night. The night nurses come on at eleven and work until seven in the morning. There is one maid for this section. She cleans the floors and polishes the furniture. No other helper of any kind is hired. All other work, cleaning of beds and sterilizing of utensils is done by the nurses.

Each morning a nurse is assigned to two patients, if the patient is extremely ill, only one. She cares for each patient just as she would if she were on private duty. She gives him all of his medicines and treatments. One patient is usually newly operated upon; the other, a convalescent. The newly operative case is cared for first. After the bath the patient rests or sleeps while the nurse goes to the convalescent patient. While five nurses are taking care of five patients, it is quite important for one nurse to be on the floor to answer lights promptly. People do not mind being left alone, if they have the assurance that they are being watched closely.

On the day of operation, if it is a major one, a nurse remains with the patient for the entire day, being relieved for hours off from one to four. Before going off duty at seven in the evening, she gives him a complete bath, changes his bed linen throughout, and makes him as comfortable as possible for the night. We have found that this complete, warm, soap and water bath is as effectual as a hypodermic to the sick and most comforting to them. One relief nurse specials the patient from seven in the evening until eleven. She also helps on the floor with the evening work, if there are many treatments and medicines to be given. The night nurses follow this same method and the patient is not left alone for any length of time during the first twenty-four hours.

A central service kitchen, recently installed, has not yet been put in operation so that we serve our trays from the diet kitchen on the floor. We give the trays very special attention and try to satisfy the individual tastes of the patient.

Our charge to the patient for group nursing is $6 per day of twenty-four hours, plus the price of his room. Patients may stay as long as they wish. Some move to wards at the end of twenty-four hours or to private rooms not in the group nursing section, but the majority stay in the department.

In comparing the cost of group-nursing service with twenty-hour private duty service for the patient, there is a daily saving of $3.50. The salary of a twenty-hour-duty nurse is $8 per day, and the hospital charges the patient $1.50 for the nurse's board. Where the patient's condition is such that two twelve-hour-duty nurses are required, group nursing service would save him $11 daily.

There are other reasons besides financial ones why group nursing is successful. The patient does not have to be left alone for four hours in the afternoon as he is when on twenty-hour duty. He does not have to consider a nurse. Many a patient has lain awake for hours, putting off calling a nurse for something that he needed badly. A sick person should not have to feel that he ought ever to consider a nurse. Our patients enjoy seeing the different nurses come into the room. If a patient should go into shock or if some other catastrophe should occur, several nurses are available until the condition is such that the nurse assigned to the room is able to manage the situation alone.

The advantages to the nurse are:

1. Steady employment.
2. Recreation hours, a day off a week without loss of salary, two weeks' vacation on pay each year.
3. Undisturbed sleep.
4. No anxiety concerning what, where or how long the next case will be.
5. An opportunity to use the budget system of saving.

The advantage to the hospital is satisfied patients.

Cancer

An Outline of a Series of Studies

JOHN M. SWAN, M.D.

IN the systematic attack on the cancer problem originated and developed by the American Society for the Control of Cancer in 1913, the assistance that may be looked for through coöperation of the graduate nurse has been recognized.

Nurses can give valuable help: first, by making themselves reliable sources of authentic information with respect to the prevention, recognition, and cure of cancer; second, by detecting cases which would otherwise escape recognition until they had passed to an incurable stage; third, by exerting an intelligent influence upon those who have cancer in its early and curable stages, and inducing them to seek immediate competent treatment; fourth, by exerting through their enlightened intelligence an influence against the operation of quacks and other incompetent persons who but add to the plight of cancer patients.

Furthermore, they may use their influence to discourage the employment of patent medicines of all kinds.

It seems desirable that those engaged in the education of nurses, should devote a portion of the time given to theoretical studies to an understanding of cancer and its various manifestations. To that end, the following syllabus is offered for the guidance of the teachers. It is suggested that twelve periods be devoted to this subject, spaced according to the available time in the course given in the different schools.

The following publications may be used as texts for the class. All are available upon application to the American Society for the Control of Cancer, 25 West 43rd Street, New York City, and will be furnished without charge. Principals of Schools of Nursing in New York State may obtain them upon application to the New York State Committee of the American Society for the Control of Cancer, 457 Park Avenue, Rochester, N. Y., also without charge.

FOR REQUIRED READING

I. WHAT EVERYBODY SHOULD KNOW ABOUT CANCER.

II. THE PREVENTION OF CANCER. By James Ewing. (Reprinted from the *Forum*, March, 1927.)

III. CANCER CONTROL: HOW THE NURSE CAN HELP TOWARD ITS ACCOMPLISHMENT.

IV. POPULAR EDUCATION AS A FACTOR IN THE CANCER PROBLEM. By John M. Swan. (Reprinted from the *New York State Journal of Medicine*, Sept. 15, 1927.)

FOR SCHOOLS IN NEW YORK STATE

V. THE CANCER SITUATION IN THE STATE OF NEW YORK, I. By John M. Swan. (Reprinted from the *New York State Journal of Medicine*, Jan. 1, 1927.) (Reprints from this paper are exhausted. The files of the Journal should be consulted.)

VI. THE CANCER SITUATION IN THE STATE OF NEW YORK, II. 1926 Statistics.

By John M. Swan. (Reprinted from the *New York State Journal of Medicine*, March 15, 1928.)

Nursing Schools and Individuals Desiring More Detailed Information than that Contained in the Above Publications May Use the Following List

FOR COLLATERAL READING, THE FOLLOWING TEXTBOOKS AND MONOGRAPHS ARE SUGGESTED

NEOPLASTIC DISEASES: A TREATISE ON TUMORS. By James Ewing. (Ed. 2, Philadelphia, Saunders, 1922.)

CANCER CONTROL: REPORT OF AN INTERNATIONAL SYMPOSIUM HELD UNDER THE AUSPICES OF THE AMERICAN SOCIETY FOR THE CONTROL OF CANCER, Lake Mohonk, New York, U. S. A., September 20–24, 1926. (The Surgical Publishing Company of Chicago, 1927.)

THE PRINCIPLES AND PRACTICE OF MEDICINE. By the late Sir William Osler & Thomas McCrae. (Ed. 9, New York and London, D. Appleton & Co., 1923.)

SURGERY: ITS PRINCIPLES AND PRACTICE. By Astley Paston Cooper Ashhurst. (Ed. 3, Philadelphia, Lea and Febiger, 1927.)

GYNECOLOGY. By William P. Graves. (Ed. 2, Philadelphia, Saunders, 1921.)

THE PRINCIPLES AND PRACTICE OF DERMATOLOGY. By William Allen Pusey. (Ed. 4, New York and London, D. Appleton & Co., 1924.)

UROLOGY. By Edward L. Keyes. (New York & London, D. Appleton & Company, 1923.)

OPERATIVE SURGERY. By Alexis Thomson and Alexander Miles. (Ed. 3, London, Frowde and Hodder & Stoughton, 1921.)

SURGERY OF NEOPLASTIC DISEASES BY ELECTROTHERMIC METHODS. By George A. Wyeth. (New York, Hober, 1926.)

X-RAYS AND RADIUM IN THE TREATMENT OF DISEASES OF THE SKIN. By George M. Mackee. (Philadelphia, Lea and Febiger, 1921.)

RADIOGRAPHY AND RADIOTHERAPEUTICS. By Robert Knox. (Ed. 4, 2 vols. New York, Macmillan, 1923.)

RADIUM IN GYNECOLOGY. By Charles C. Norris and John G. Clark. (Philadelphia, Lippincott, 1927.)

While these textbooks are suggested, there is, of course, no reason why any other standard text available should not be substituted for any or all of them.

THE COURSE

I. THE NATURE OF CANCER. Point to emphasize—The unit of cancer formation is a normal body cell that has begun to reproduce without obedience to the laws governing the growth and arrangement of normal tissues.

Read the paper by Maude Slye, *Journal of Cancer Research*, 1927. 11: 135, and the article by William H. Woglom, *Atlantic Monthly*, June, 1928. 14: 806.

A. THE CAUSE. Point to emphasize—The cause of the malignant reproduction of the body cells is not known, but is always associated with some form of chronic irritation. Read Ewing, chapter VI, p. 94; chapter VII, p. 109; chapter VIII, p. 113.

B. COMMUNICABILITY. Point to emphasize—Cancer is not contagious.

C. HEREDITY. Point to emphasize—Cancer is not hereditary. A hereditary tendency may exist; but if chronic irritation is avoided, cancer will not develop. Read Ewing, p. 105.

D. METASTASIS. Point to emphasize—The cancer cell, leaving the point of its original development, being carried by the lymph, or by the blood, will produce another cancer (metastatic) at the point or points in other organs in which it is arrested. Read Ewing, p. 76.

II. THE PATHOLOGICAL CONDITIONS THAT ARE FOLLOWED BY THE DEVELOPMENT OF CANCER: THE PRECANCEROUS LESIONS. Read Ewing, p. 475.

A. MOLES. Point to emphasize—Moles, particularly if they are dark in color, have hairs growing from them, and are situated where they may be irritated by rubbing of the clothing, may develop melanotic sarcoma. Read Ewing, p. 872; Pusey, p. 902.

B. KERATOSES. Point to emphasize—Keratoses are often the forerunners of cancer of the skin. Read Pusey, p. 881.

C. CHRONIC ULCERS AND FISSURES. Point to emphasize—Chronic

sores that do not heal readily are often the starting point for the development of cancer. Read Pusey, p. 99 and 100.

D. Gall Stones. Point to emphasize—Cancer of the gall bladder and of the liver is often preceded by gall stones and inflammation of the gall bladder and the bile ducts. Read Osler, p. 560.

E. Gastric Ulcer. Point to emphasize—Cancer of the stomach is often a sequel of ulcer of the stomach. Read Osler, p. 481; Cancer Control, p. 103.

III. The Pathological Conditions That Are Followed by the Development of Cancer: the Precancerous Lesions (Continued). Read Ewing, p. 475.

F. Lacerations of the Cervix Uteri. Point to emphasize—Cancer of the uterus is often a sequel of low-grade, chronic inflammation in a cervical tear. Read Graves, p. 334.

G. Cystitis. Point to emphasize—Chronic cystitis is sometimes followed by the development of cancer of the bladder in both men and women. The first indication of the development of cancer in this organ is the passage of blood with the urine. Read Graves, p. 427. Ashhurst, p. 991.

H. Leukoplakia. Point to emphasize—Cancer often develops at the site of leukoplakia. Read Pusey, p. 1208.

I. Paget's Disease. Point to emphasize—Paget's Disease of the nipple is often a forerunner of cancer of the breast. Read Pusey, p. 1084.

J. Benign Tumors. Point to emphasize—Benign tumors, particularly adenoma and fibroadenoma, sometimes undergo malignant change. Read Ewing, p. 478. Ashhurst, p. 110.

K. Hemorrhage from any of the hollow viscera should be looked upon as the first indication of cancer if it cannot be explained by some obvious injury or inflammatory process. This applies particularly to irregular bleeding in women just before, or at the time of the menopause.

IV. The Different Kinds of Malignant Tumor:

A. Epithelioma. Read Ewing, p. 474. Ashhurst, p. 113.

B. Carcinoma. Read Ewing, p. 461. Ashhurst, p. 112.

C. Sarcoma. Read Ewing, p. 240. Ashhurst, p. 106.

D. Hypernephroma. Read Ewing, p. 775. Ashhurst, p. 120.

E. Glioma. Read Ewing, p. 399. Ashhurst, p. 611.

V. Cancer of the Skin. Read Ewing, chapter XLII, p. 818; Pusey, p. 1057; Ashhurst, p. 116.

VI. Cancer of the Lip, Tongue, Mouth, and Tonsil. Read Ewing, p. 840; Ashhurst, pp. 670, 679, 695.

VII. Cancer of the Stomach. Read Ewing, chapter XXI, p. 625; Osler, p. 489; Ashhurst, p. 902.

VIII. Cancer of the Rectum. Read Ewing, p. 667; Ashhurst, p. 944, and Graves, p. 429.

IX. Cancer of the Uterus. Points to emphasize—Cancer of the cervix occurs almost exclusively in women who have had long standing, low-grade infection, frequently in a laceration and usually the result of childbirth. Cancer of the body of the uterus is often found in association with uterine fibroids. Read Ewing, chapter XXVII, p. 543; Ashhurst, p. 1137; Graves, p. 334 (cervix), 362 (body).

X. Cancer of the Breast. Read Ewing, p. 506; Ashhurst, p. 742.

XI. The Prevention of Cancer. Read Ewing's paper reprinted from the *Forum*. Also, Cancer Control, p. 165.

XII. The Treatment of Cancer:

A. Surgical Operations. Thomson & Miles, chapter 1, p. 1. Breast, p. 237; stomach, p. 306; rectum, p. 376.

B. Refer to Collateral Reading List. Books by Mackee, Knox, Clark & Norris.

C. Endothermy. Wyeth, chapter III, p. 19; chapter IV, p. 39; chapter V, p. 57; chapter VI, p. 73.

See also the sections on treatment in the texts referred to in the other exercises.

Meeting the Need of the Small and Rural Hospital[1]

ALMA C. HAUPT, R.N.

IT is a significant fact that this large group of nurses, meeting in the largest metropolis of the world, should devote two papers of today's session to the consideration of small hospitals. It is further significant that in this morning's session the small hospital is placed between the Scylla of "The Official Registry" and the Charybdis of "Hourly Nursing"—whereas on the afternoon program, it stands between "Staff Education," on the one hand, and "Extra-curricular Activities in Nursing Education," on the other.

The deduction naturally is that every member of the New York State Nurses' Association is tremendously interested in the small and rural hospital and sees it occupying a central point around which revolve several of the subjects which are puzzling to the nursing world.

The subject of this paper, "Meeting the Need of the Small and Rural Hospital," brings up the primary question: What is the need of the community in which such a hospital is to be located? Let us consider the needs of rural areas in this country for health service. We read in the papers that Dr. William J. Mayo, speaking before the recent meeting of the American College of Surgeons, in Boston, emphasized the scarcity of competent physicians in country districts and admonished the medical profession to find a solution.[2] We know that approximately half of all counties in the United States lack reasonable access to hospitals. The *Survey* for October 15, 1928, states:

> At the rate of progress which existed from 1920 to 1928, it will take some fifty-five years to extend reasonably adequate full-time rural health service to all the counties of the United States where such service is needed. More than 80 per cent of the rural population is as yet unprovided with official local health service "approaching adequacy."

Such is the problem—how is it being met? Fortunately, a number of agencies are concerned with the extension of public health service to rural areas, among them the United States Public Health Service, the Children's Bureau, the various state boards of health, the American Public Health Association, the American Red Cross, the International Health Board and several foundations, including those interested in the child health demonstrations.

In the field of education we find a number of medical schools offering extension courses to rural physicians and the Albany Medical College making particular effort to educate young physicians for rural practice. The eleven postgraduate public health nursing courses endorsed by the N. O. P. H. N. give consideration to the preparation of the rural public health nurse and have limited access to county health units for practical experience. Increased opportunity for field work in rural public health nursing is decidedly necessary.

The rural hospital situation is receiving increased attention. There are interesting developments in Kentucky under the auspices of the Frontier Nursing Service. The Duke Foundation is building small hospitals throughout North and South Carolina.

[1] Read at the annual meeting of the New York State Nurses' Association, Brooklyn, October 25, 1928.

[2] *New York Herald-Tribune*, October 15, 1928.

The Rural Hospital Program of the Commonwealth Fund at present provides assistance to six small hospitals in six different states.

Turning now to the needs of the small and rural hospital, we may describe the operation of the units in the Commonwealth Fund program. This will serve to illustrate the problems involved and at least some methods for solving these problems. It should be borne in mind that in a situation so new and experimental as the rural hospital field, no fixed standards can at this time be laid down. Plans must be kept flexible and adapted to each different community. Those of you who are chiefly interested in the small hospital in large cities may see certain practices applicable to your situation, and others which fit only a rural hospital.

The first need of the small hospital is an interested community which can be properly organized for financial support and for educational work in both preventive and remedial medicine. No less than two hundred and fifty communities were sufficiently interested to make application for participation in the Rural Hospital Program. In each of the six selected from this number, a lay board of directors was formed, representative of various interests and various geographic parts of the district.

Although women are invariably included as board members, it has been feasible to organize a separate women's auxiliary which makes certain definite appeals to feminine tastes and ability. The women's auxiliaries take over the raising of money for hospital linen, the making of special supplies, the provision of flowers and books for patients. In one instance there is a "Grounds Committee" for attention to the lawns and window boxes; in another, a "Pantry Committee" to provide such home-made delicacies as jellies and jams to be enjoyed by both patients and members of the staff.

The hospital board is not complete without some definite organization connection with public health. Usually the county or district health officer is a member of the medical staff of the hospital. Where organized public health work has antedated the establishment of the hospital, it is probable that the same laymen who support public health activities are also on the hospital board. This offers two possibilities in organization —either the formation of a so-called "hospital and health council" with representatives from both groups, or a sort of interlocking directorate, a public health committee, on which sit certain hospital representatives, and a hospital board with some members especially appointed for their interest in public health. In the latter case, a coördinating committee to attend to matters involving joint program and joint finance is possible.

The first project, after that of organization, is that of finance. The Commonwealth Fund offers to pay two-thirds of the capital cost, provided the local board raises the remaining one-third and guarantees the maintenance. An average sum of $275,000 (which varies according to local building conditions) provides for a hospital building and equipment to care for fifty patients and a separate nurses' home housing some twenty people.

These fifty-bed general hospitals serve a district approximately thirty-five miles in radius in which there is no town of more than 12,000 inhabitants. Every doctor within the district who is in good standing professionally is invited to become a member of the medical staff. This staff is organized and selects its own chairman. Staff

members take service for indigent cases in rotation. A consultation service of eminent specialists from near-by medical centers is also arranged and medical men in the district who are too remote to be on the regular staff may become "visiting staff members" and have the full privilege of sending in patients to be referred to the regular staff men.

It is essential in each small hospital that there be a medical resident—a young physician who has already had his internship and wishes an additional year of hospital experience. He attends to emergencies, gets histories, sees that medical records are properly written up and assists the medical staff and the superintendent in a variety of ways.

The Rural Hospital Program offers two educational opportunities to local physicians. Five fellowships a year are available for physicians in each district to attend postgraduate courses in the best medical schools of the country. Those physicians who have already availed themselves of the fellowships and who are now returned to their practices consider the experience one of great value. Whereas fellowships reach a comparatively small number of doctors a year, medical institutes conducted twice annually are available to every physician in the district. Clinics, demonstrations, lectures and discussions are held under the leadership of medical teachers of repute and are proving stimulating and helpful to the local medical profession.

The superintendent of the small hospital is the connecting link between the board of directors, the medical staff, the nursing and other personnel and the patients. Nurse superintendents are usually the most successful in these positions. The broad scope of the Rural Hospital Program calls for a superintendent of unusually broad background and big vision. It is necessary that she have experience in hospital-administration problems as distinguished from those of a school of nursing. There are relatively few available nurses with this experience and there are at the present time practically no courses which definitely prepare nurses to be hospital administrators. As a substitute for courses for superintendent preparation, arrangements have been made in individual cases for a period of a few months' observation and practice under the personal direction of one or two of the outstanding leaders in the hospital-administration field.

A graduate nurse staff is employed in the hospitals now in operation. The nurses live in attractive quarters, consideration is given their social and recreational needs, and professional stimulation is maintained through helpful supervision, rotation of services and weekly staff conferences.

Educational opportunities for the graduate nurses are similar to those for the local physicians. A limited number of fellowships are offered to nurses in the district, those on the hospital staff, those doing public health, those engaged in private duty. These fellowships allow for a few months' study in whatever branch of nursing best fits the student's needs and her anticipated future work in the rural hospital district.

The first institute for nurses was held in the Southside Community Hospital, Farmville, Virginia, in September. About forty nurses attended, representative of every branch of the profession. The two-day program consisted of lectures and demonstrations, each subject being discussed from two standpoints, one that of hospital practice and technic, the other that of home care as given either

by the public health or the private duty nurse. The two invited nurse speakers are well-recognized instructors, one in a school of nursing, the other in a postgraduate course for public health nurses. In addition, questions of organization and standards of public health were discussed by the Field Director of the American Public Health Association. The presence of the State Health Officer and a number of his supervising nurse staff contributed much to the discussions. Here was a real pooling of thought; here was one body of nurses thinking out the question: What are the needs of our rural area for nursing care? It was difficult to distinguish between hospital, public health and private duty nurses. Each group seemed genuinely interested in the work of the other. The public health nurses said they were simply "thrilled" to watch a finished demonstration of a typhoid sponge. The hospital staff were fascinated to see all that came out of the visiting nurse's little black bag and to have skillfully enacted before them the technic of a home visit. Twice a year institute programs are being planned, thus bringing to the rural nurse new professional stimulus, a review of technic, and the opportunity to develop. It is anticipated that when nurses in rural districts have good conditions of living, recreational opportunities and such contacts with groups of nurses, that they feel they belong to the profession and are keeping up with its progress, then better-prepared nurses will go to rural districts, there will be less turnover, and an adequate service to the rural population will be provided.

There is just one other need of the small and rural hospital which it is essential to mention here—that is its need for a public health program. The hospital and the public health program are tremendously important to each other. How effective is a hospital unless there are other forces at work teaching the people to keep well, unless immunizations are made possible, unless good sanitation is accomplished, unless public health workers can follow up hospital patients for after-care and education? Is not a public health program incomplete which has no diagnostic facilities, no hospital for the correction of the physical defects discovered, let us say, in the school health work? There are times when it is of utmost importance to the public health to hospitalize a communicable-disease case, and again times when a hospital out-patient department seems indispensable to the public welfare. Obviously, then, there is need for parallel development of hospital and health activities, for wise leadership, both lay and professional, for gradual education of the people in rural communities to a higher, better and healthier standard of living.

Perhaps as the needs of the small and rural hospital have been thus described, you, as members of the nursing profession, have been taking them sufficiently seriously to heart to question "What can we as nurses do about it?" Briefly, and by way of conclusion, there are three opportunities for you to contribute:

First. In the education of student nurses, all of you can keep in mind nursing needs in small communities and help to prepare and interest your nurses to go back to rural districts.

Second. Graduates, on asking themselves, "What next?" should appreciate the opportunities awaiting them in the small hospital and the rural community.

Third. The nursing profession, as a whole, should coöperate to the fullest with the Grading Committee in the finding of the facts regarding nursing.

One of the chief weaknesses the

Grading Committee has so far revealed regarding nursing is that there is a faulty distribution of nurses—too many in big centers, too few in the small. Let us hope that the fault will partially be corrected as the needs of the small and rural hospital are properly met.

The Community and Nursing[1]

"NURSING is an art that concerns every family in the world," said the founder of modern nursing more than a half-century ago. This being true, it might further be said that nursing is an art that concerns every community in the world. Communities will vote bond issues for good roads; they will do the same for schools; they have not very generally thought of nursing as a social service for which the community might or should hold itself responsible. Probably this is because nursing in its older form was one of the works of charity of the Christian church. Modern nursing, holding fast to many of the lovely traditions of the older order, requires also a scientific preparation for the demanding tasks set for it by the teachings of modern medicine and the steadily expanding field of public health.

The women of a community may well ask themselves these questions:

1. What legal restrictions are thrown about the practice of nursing in this state? Relatively few people know that every state in the Union has a "Nurse Practice-Act" passed primarily to protect the public and that only nurses who have met the requirements of these laws are qualified to practise as registered nurses.

2. Who provides the professional education necessary for efficient nursing? Is it the state, as in teaching, in medicine, and the other professions?

3. Is the nursing service of our community well organized? That is, have we provided public health nurses in sufficient numbers to serve the health of the community by giving bedside care to the sick in their homes and by teaching and demonstration to promote principles of healthful living and guard against the spread of infection? Are we informed as to the proper method of securing well-qualified registered nurses when we need full-time or part-time private duty nursing in our homes?

4. If we cannot secure any or all of these types of service, is the nursing profession itself at fault?

The answers to these questions should set the women of any community to thinking about two things. First, the responsibility for the education of nurses which should not be a charge upon the sick of a community but a responsibility carried by the well as an insurance against illness. Second, the importance of knowing the types of nursing service that could be made available through proper organization and coöperation with nurses. The set-up would not be identical for any two localities but all the following types of service should be thought of.

(a) Good hospital nursing service which might be provided in part by students in a school of nursing, if the hospital has suitable services, equipment and resources for teaching nurses.

(b) Private duty nursing, full-time service and also part-time service, which is sometimes called hourly nursing, unless such service for paying patients is provided by the organization which provides visiting nursing.

(c) Public health nursing may be administered by health departments, school boards, county commissioners, public health nursing associations, life insurance companies, industries and hospital out-patient departments.

"Nursing has become an essential social service. It calls for women of breeding, education and intelligence. It is essentially a woman's profession. Its progress in several states has been measurably forwarded by the sympathetic understanding and active cooperation of women's clubs. It is suggested that the clubs of all the states undertake an active study of this profession, whose service 'concerns every family in the world.' Fortunately, the means for study are being made available at just this time. A National Committee known as the Committee on the Grading of Nursing Schools is studying the whole problem. It is a committee composed primarily of educators, physicians, and nurses. The report of its supply and demand study, directed by May Ayres Burgess, Ph.D., called 'Nurses, Patients and Pocketbooks,' is now available. The book might, however, be borrowed from hospital superintendents or superintendents of nursing schools. It is commended to the thoughtful study of all women's clubs, for it bids fair to revolutionize the distribution of nursing service, a matter of first rate importance in practically every community in the land."

[1] Prepared at National Nursing Headquarters for the Public Health Division of the General Federation of Women's Clubs. Published in the official organ of the Federation for January, 1929.

School-of-Nursing Catalogues

CAROLYN E. GRAY, R.N.

RECENTLY I was asked a leading question about a well-known school of nursing. I could not answer it and referred the questioner to the announcement or catalogue of the school. To my chagrin, the answer was not to be found, though the question—about training in the care of children—was one the answer to which might reasonably be included in such a publication. This experience started me on a comparative study of the catalogues or announcements of our schools. It has proved both interesting and illuminating. I found much cause for congratulation, possibly some cause for feeling that there is still room for improvement, but I leave that to my readers to decide.

Necessarily my references must be nameless, and even though fairly exhaustive, they are not complete. I have studied only a small number of the catalogues of the 2,000-plus schools in this country, though I have deliberately chosen those of schools that are credited with being above the average and are located in different parts of the United States.

I was fortunate in securing material from some schools that have long histories, and this material proved a gold mine of information. The earliest announcement I have dates from *June, 1875*. It is a large folded sheet and is a combination announcement and application blank. It gives ample space to the "Board of Control" under which the school functions, outlines the purpose—"to give two years instruction to women desirous of becoming thoroughly experienced and educated nurses"—and tells how to make application. Entrance requirements are: "Applicants must be over twenty years of age and under thirty-five years, and must present a certificate from a responsible person and a physician as to their moral character and health."

"The hours of day duty are from 6 a. m. to 6.30 p. m. and for night duty 6.30 p. m. to 6 a. m." These are plain, unvarnished truths and no effort is made to make them attractive.

The "plan of instruction" is perhaps the most interesting, as it consists of the titles of eight lectures "delivered by medical men":

1. Nursing.
2. Hygiene and Health.
3. Food.
4. Ventilation.
5. Poisons and Antidotes.
6. Pulse, Respiration, Temperature, Bandaging and the Application of Instruments.
7. Midwifery and Children.
8. Examination of urine.

This, plus a few "don'ts," and some questions—name, age, place of birth, occupation, health, references and a statement that the applicant "was prepared to comply with the rules and regulations of the institution"—complete the announcement.

How simple it all seems and what a pity it is that copies of the lectures are not available. The titles are inclusive and to cover the material in one hour's time, after 7 p. m., was no small feat.

Several later announcements are dated *1881* and represent a distinct stride. They are still folded sheets of paper and combination announcement and application blanks. "Information for applicants" is listed on one side of the page and is more detailed and complete. Entrance requirements are the same, but the lectures have been increased by one, "Application of leeches and subsequent

treatment," so that the total is nine. In some of the announcements the titles of the lectures are amplified, *i. e.*, "Nursing; including dressings of blisters, burns, wounds and sores, applying of poultices, fomentations and minor dressings."

But the outstanding statement in each announcement is about some special advantage that the school is prepared to offer, perhaps "the largest maternity service" makes a bid for notice, or "the most modern surgical department," etc. There is little change, only different emphases, in the various announcements until about *1890*, when the names of the Superintendent and Assistant Superintendent are given equal prominence with those of the governing boards, and the names of "Advisory Boards"; later, "Boards of Examiners" are added. Perhaps the most marked change is in the hours, usually from 7 or 7.30 a. m. to 7 or 7.30 p. m., with some hours off duty, in one "an hour for dinner and when hospital duties permit additional time for rest and study. A half-day each Sunday and one other half-day each week is allowed each student, and a vacation of two weeks each year."

A noteworthy change is that, under "Course of Training," various statements are added; as, for instance, "Weekly classes will be held by the Superintendent and Assistant Superintendent, and in addition to this, instruction will be given by the House Physicians, Surgeons and Head Nurses, at the *bedside of the patient* and in various other ways. A course of lectures will be given on such subjects as Anatomy, Physiology, Hygiene, Diseases, Surgery, Materia Medica and Obstetrics, and examinations will be held at stated periods." All this in addition to doctors' lectures! The "Application Blank" part of the announcement is much more complete, many more questions are asked and one on "Educational Advantages" is allowed generous space for an answer.

All of this shows a marked improvement and the emphases on "additional teaching" and "teaching at the bedside of the patient" are new and, in many instances, seem to have crowded out the statements about various hospital services.

Then a long step in advance is taken, for shortly after *1890* many schools begin to publish small books, called variously Announcements, Catalogues, Circulars of Information, and the application blank is separate. It seems clear that applicants wanted more information, or are needed in larger numbers, for these books are much more attractive, give more detailed information, outline the "Course of Training" more definitely, eliminate the "don'ts" and substitute "Rules," even though "The hour for rising is 6 a. m." is usually one of the first statements to strike one's eye. It is in these books that we begin to have outlines of the content of classes in various subjects, grouped in the years in which they are given. These books seem to have come to stay. Subsequent issues are larger, more attractively bound, often in the school colors, with numerous and attractive illustrations; entrance requirements are based on the number of years in high school; classes and when given are definitely outlined, being in every way an effort on the part of those in charge of the school to put their best foot forward and attract as many applicants as possible.

The extent to which this boosting, or boasting, of our schools was carried produced a crop of announcements that are much more attractive than the early combination announcements

TABLE 1.—ENTRANCE REQUIREMENTS

Schools	Academic	Age	Tuition	Length of Course	Accredited	Allowance	Vacation	Hours on Duty
A	1 year high school or equivalent	Not stated	None	3 years	Yes (N. Y. S.)	All uniforms and text-books $10 per mo. after prelim.	4 weeks each year	8-hour day and night 2–4 hrs. per day during prelim.
B	1 year high school or equivalent	18–35 years	$10 lab. fee	3 years	Yes (N. Y.)	$20 per month	2 months	Not stated
C	4 years high school or full equivalent	18–30 years	$50 $10 breakage	3 years	Yes (N. Y.)	Uniforms and text-books (after accepted)	10 weeks	Prelim., 20 hrs. a week; day duty. 52 hrs. per week; night duty. 56 hrs. per week
D	4 years high school or full equivalent	19–35 years	None	3 years	Yes (N. Y.)	Uniforms and text-books (after accepted)	3 weeks during 2nd and 3rd year	8-hour day
E	4 years high school or its equivalent	Not stated	$10 registration fee	3 years	Yes (N. Y.)	None—has loan fund	1 month each year	8-hour day
F	High school graduates	19–35 years	None	3 years	Yes (N. Y.)	$6 per mo. after prelim., then 2nd and 3rd yrs. $7 per mo.	3 weeks each year	Prelim. 2–4 hrs. per day; 8-hour day; 10-hour night
G	Full high school or its equivalent	19–35 years	$10 registration fee	3 years	Yes (N. Y.)	$5 during prelim., $20 per mo., excepting during periods of affiliation	3 weeks each year	Prelim. 2–5 hrs. per day; 8-hour day, 10-hour night
H	Full high school	18 years	None	2 years 4 months	(N. Y. ?)	$7.50 per mo. after prelim. period	2 weeks each year	Prelim. 4 hrs. per day; 7½-hour day, 1 short day per week; 7-hour night
I	Full high school	18–35 years	None	2 years 4 months	Yes (N. Y.)	$20 per mo. 1st year, incl. prelim. period. $30 per mo. balance of time. Uniform material for seniors	Not stated	Prelim. 3 hours per day; 1 day off per week; 8-hour day, 1 day off each week

and application blanks, but most of them have left out the older type of statement about special opportunities in the hospital, and some seem to have pushed the hospital training so far into the background that it is only on the covers of the catalogue that the name of the hospital is mentioned at all.

Such extreme forms of advertising have brought their own cure until today many of the announcements of our schools resemble college catalogues. And their resemblance to college catalogues is sometimes more striking than seems desirable because there is so little mention of the hospital portion of the education offered. After all our schools are vocational schools aiming for the status of professional schools and offering a special type of education that is definitely related to the care of patients in the

TABLE 2.—SUBJECTS TAUGHT—HOURS—BY WHOM

Schools	Anatomy and Physiology	Bacteriology	Dietetics	Elementary Materia Medica	Household Economics	Personal Hygiene	Principles of Nursing	History of Nursing	Physical Education	Pathology	Advanced Nursing	Surgical Orthopedics	Massage	Materia Medica	Gynecological Nursing
A	90 Nurse	32 Nurse	45 Dietitian	30 Nurse	30 Nurse	15 Nurse	185 Nurse	15 Nurse	30 Specialist	20 Doctor	15 Nurse	20 Doctor	18 Masseuse	20 Nurse	10 Doctor
B	105 Nurse	45 Nurse	45 Dietitian Doctor	15 Nurse	With Nursing Nurse	45 Nurse	150 Nurse	15 Nurse	* *	15 Doctor	30 Nurse	63 Doctor	15 Masseuse	30 Nurse	6 Doctor
C	80 Nurse	30 Nurse	48 Dietitian	20 Nurse	With Nursing Nurse	With Physiology Nurse	384 Nurse	16 Nurse	4 Specialist	4 Doctor	16 Nurse	64 Doctor Nurse	12 Masseuse	20 Nurse	With Surgery Doctor Nurse
D	84 Not stated	60 Not stated	48 Not stated	* *	* *	8 Not stated	90 Not stated	12 Not stated	* *	3 Not stated	* *	24 Not stated	* *	56 Not stated	7 Not stated
E	90 Nurse	70 Nurse	45 Dietitian	15 Nurse	15 Nurse	15 Doctor Nurse	105 Nurse	20 Nurse	15 Specialist	30 Doctor	6 Nurse	36 Doctor Nurse	15 Masseuse	30 Nurse	15 Doctor Nurse
F	93 Nurse	51 Doctor	48 Dietitian	30 Nurse	15 Nurse	15 Nurse	60 Nurse	14 Nurse	* *	7 Doctor	9 Nurse	35 Doctor	12 Masseuse	30 Nurse	10 Doctor
G	100 Nurse	30 Doctor	48 Dietitian	20 Nurse	10 Nurse	10 Nurse	108 Nurse	20 Nurse	* *	25 Doctor	14 Nurse	68 Doctor	10 Masseuse	25 Doctor	10 Doctor
H	60 Nurse	24 Nurse	32 Dietitian	16 Nurse	* *	8 Nurse	154 Nurse	8 Nurse	* *	10 Doctor	16 Nurse	22 Doctor Nurse	* *	16 Nurse	8 Doctor
I	52 Nurse	20	64 Dietitian	30 Nurse	* *	8 Nurse	64 Nurse	8 Nurse	* *	14 Doctor	23 Nurse	22 Doctor Nurse	14 Masseuse	16 Nurse	6 Doctor

* Not given.

hospital or hospitals with which the school is connected. Failure to emphasize the value of the hospital experience seems comparable to offering nutshells with the nuts left out.

A study of the catalogues of 1928 is rewarding, particularly if compared with earlier issues. The space formerly given to "Boards of Control" is now shared with a list of faculty members, their academic and professional education often making a creditable showing, though this is not true as often as one would wish. The date of graduation of faculty members makes one wonder if recency is an asset, and there is much evidence of inbreeding, even though we are prone to disguise this under the name of "School Loyalty" and I claim justification for the use of capitals! In some cases the only member of the School of Nursing Faculty with a degree is *not* a nurse!

It is not always clear just what each faculty member teaches, though the outlines of the classroom subjects are more complete than that of the corresponding hospital services. I have found only one catalogue that gives the hours per day, weeks, etc., of each service, so that the full number

TABLE 2.—SUBJECTS TAUGHT—HOURS—BY WHOM—(*Continued*)

Medical Nursing	Dietotherapy	Obstetrics	O. R. Technic	Eye, Ear, Nose, Throat	Pediatrics	Mental and Nervous Diseases	Public Sanitation	Communicable Diseases	Ethics	Parliamentary Law	Chemistry	Psychology	Professional Problems	Special Therapeutics Occupational Therapy	Special Lectures
20 Doctor	15 Dietitian	20 Doctor	10 Nurse	15 Doctor	20 Doctor	20 Doctor	15 Doctor	20 Doctor	10 Nurse	10 Nurse	• •	• •	• •	• •	• •
45 Doctor	15 Doctor	45 Doctor	15 Nurse	18 Doctor	45 Doctor	30 Doctor	15 Doctor	24 Doctor	15 Nurse	• •	45 Nurse	15 Doctor	15 Nurse	15 Specialist	1 •
32 Doctor Nurse	• •	60 Doctor Nurse	• •	• Inc. in specialties	24 Doctor Nurse	16 Doctor Nurse	8 Doctor	16 Doctor Nurse	16 Nurse	• •	24 Nurse	8 Doctor	30 Nurse	• •	20 Specialist
30 Not stated	10 Not stated	24 Not stated	• •	6 Not stated	28 Not stated	10 Not stated	10 Not stated	20 Not stated	6 Not stated	• •	48 Not stated	8 Not stated	25 Not stated	• •	• •
30 Doctor Nurse	15 Dietitian	30 Doctor Nurse	9 Nurse	15 Doctor Nurse	30 Doctor Nurse	30 Doctor	15 Doctor	24 Doctor Nurse	10 Nurse	• •	45 Nurse	30 PH.D. Nurse	30 Nurse	• •	36 Specialist
30 Doctor	30 Doctor	30 Doctor	10 Nurse	12 Doctor	30 Doctor	15 Doctor	8 Doctor	15 Doctor	10 Nurse	• •	36 Doctor	• •	15 Nurse	15 Specialist	15 Specialist
35 Doctor	20 Doctor	24 Doctor	• •	22 Doctor	60 Doctor	18 Doctor	12 Doctor	26 Doctor	10 Nurse	• •	30 Nurse	10 Doctor	10 Nurse	45 Specialist	• •
16 Doctor Nurse	8 Dietitian	20 Doctor Nurse	8 Nurse	6 Doctor	20 Doctor Nurse	12 Doctor	8 Nurse	20 Doctor Nurse	8 Nurse	• •	24 Nurse	8 Doctor	12 Nurse	• •	4 Specialist
18 Doctor	12 Dietitian	14 Doctor	8 Nurse	6 Doctor	15 Doctor	12 Doctor	8 Doctor	18 Doctor	8 Nurse	• •	64 Nurse	• •	30 Nurse	• •	• •

• Not given.

of months is accounted for. This seems an extraordinary omission, when our hospital experience is the unique thing about our particular form of education. Haven't most of us waxed eloquent over the advantages of hospital experience as compared with correspondence schools? Inasmuch as all the subjects taught in the classroom have for their purpose, making the student a more intelligent, understanding, humane and interested nurse, it seems strange that the opportunity to apply this teaching in actual care of the sick is not given as much space, and as clear and definite an outline, as any other. Strange, too, how few catalogues list the teaching done at the patient's bedside. Surely it can't be true that all the teaching is done in the classrooms?

In support of my contention that there are startling omissions even in the 1928 catalogues and that, while much ground has been gained, there is still much that we must make our own if our catalogues are to meet their purpose, I submit Tables 1, 2, and 3.

Number 1 is fairly complete. Number 2 is more nearly complete, only one wonders why the names of the faculty are not connected in any way with

TABLE 3.—SERVICE ON WARDS

Schools	Preliminary Period	Medical	Surgical	Obstetrical	Pediatric	Diet Kitchen	Operating Room	O.P.D. Visiting Nurse	Tonsils and Adenoids	Communicable Disease	Neurological	Psychiatric	X-Ray	Social Service	Electives	Eye	Ear, Nose, Throat	
A	4 mos.	5 mos.	7 mos.	3–4 mos.	3 mos.	6 wks.	2–3 mos.	4 mos.	*	*	*	*	*	*	2–3 mos.	*	*	
B	5 mos.	4 mos.	4 mos.	3 mos.	3 mos.	1 mo.	2 mos.	1 mo.	1½ mos.	*	With Psychiatry	1½ mos.	2 mos.	*	4 mos.	1 mo.	1 mo.	
C	4 mos.	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	
D	4 mos.	Not stated	Not stated	10–12 wks.	*	4 wks.	12–14 wks.	Not stated	*	*	Not stated	*	*	Not stated	*	*	*	
E	6 mos.	22 wks. incl. diets	28 wks.	12 wks. incl. dist.	20 wks. incl. contagion	See Med.	*	10 wks.	*	See Pediatrics	*	*	*	*	16 wks.	*	*	
F	3 mos.	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	*	Not stated	Not stated	Not stated	Not stated	Not stated	
G	4 mos.	6 mos.	6 mos.	3 mos.	2 mos.	10 wks.	3 mos.	*	*	*	*	*	Laboratory 1 mo.	*	6 mos.	*	*	
H	4 mos.	Not stated	Not stated	12 wks.	12 wks.	Not stated	Not stated	Not stated	Not stated	6 wks.	*	*	*	*	*	*	*	
I	4 mos.	Not stated	Not stated	Not stated	Not stated	Not stated	Not stated	*	Not stated	Not stated	Not stated	*	*	*	*	Not stated	Not stated	

* Not given.

what they teach, and—fearful question—do they all teach? If not, why listed[1] as faculty members?

Number 3 is the one that is most incomplete. "Not stated" appears too often. Why is it that the time to be spent in each service is not listed? Is it that we have always had these services and so take such educational opportunities for granted, or is it that we fail to appreciate the unique value of the hospital services? I can't think the latter is true, and instead I wonder if the exigencies of the work make it unwise to pledge each student a definite time in each service and, if definite periods were listed in the catalogue, it might be awkward if it were impossible to live up to them? But what a pity, for the catalogue would be so much more complete if this were done.

Not only the catalogues included in the table, but many others, make a very poor showing in this respect. We are taught that one way to hold interest and help individuals to remember is to give them the facts wanted at the time they feel the need for them. Surely prospective students, or their parents, "feel the need for" facts at the time when they consult the school catalogues. And we mean to give them facts, but are we succeeding?

One more point; is it too much to expect that the number of hours of instruction and the number of hours of actual work in each service should be totalled and set opposite each other? It would then be easy to get a grand total of the number of hours of instruction and the number of hours of work spent applying it.

In many catalogues one finds the statement that, when sick, students "are cared for gratuitously." Doesn't this suggest that sickness is inevitable, and though the word gratuitous is meant to be reassuring, isn't it almost too obvious? "Could the hospital do less?" was the rejoinder of one mother, not too well pleased that her daughter wanted to study nursing. Would it be possible to change the emphasis from a negative one to a positive one on the prevention of sickness and the promotion of health habits?

I know full well that it is not easy to make up a catalogue that includes answers to all the questions that may be asked, and to have it accurate and attractive as well. But that is the goal we must strive for and the object of this paper is to show that having gone so far, we can go farther and do better.

[1] These lists do not appear in Table 2, but are found in almost all 1928 catalogues.

Suggested Books on Social Hygiene

CADY, BERTHA C. AND VERNON M. *The Way Life Begins.* New York: American Social Hygiene Association, 1917. $1.50.

DE SCHWEINITZ, KARL. *Growing Up.* New York: Macmillan, 1928. $1.75.

ELLIS, HAVELOCK. *Little Essays of Love and Virtue.* New York: Doran, 1922. $1.50.

GALLOWAY, T. W. *Sex and Social Health.* New York: American Social Hygiene Association, 1924. $2.50.

GALLOWAY, T. W. *Parenthood and the Character Training of Children.* New York: Methodist Book Concern, 1927. $1.10.

GRAY, A. H. *Men, Women and God.* New York: Doran, 1923. $1.50. New York Association Press, 1923. 60 cents.

GROVES, E. R. *Social Problems of the Family.* Philadelphia: Lippincott, 1927. $2.50.

POPENOE, PAUL. *The Conservation of the Family.* Baltimore: Williams and Wilkins, 1926. $3.

POPENOE, PAUL. *Modern Marriage.* New York: Macmillan, 1925. $2.50.

ROYDEN, A. M. *Sex and Common Sense.* New York: Putnam, 1922. $2.50.

—American Social Hygiene Association, Inc., 370 Seventh Avenue, New York.

A Study of the Nursing Care Given to Pneumonia Patients in the Cook County Hospital

The study which follows was presented in the class in Ward Administration by Gladys Sellew, Assistant to the Dean, at the Illinois Training School for Nurses, Chicago. The study was prepared by Mrs. Grace Gagnon, a supervisor in medical nursing, and Harriet Burnette, a postgraduate student, under the direction of Alma Dieson, Assistant to the Dean, in charge of one of the two divisions of medical nursing instruction and service. Dr. Robert Keeton of the attending medical staff has also coöperated in the editing of the study.

LAURA R. LOGAN, *Dean.*

THE day picture is that in use on the ward; the time study was made from actual experience with a group of pneumonia patients cared for in a small division of this large ward.

The day picture and time study could be used as a basis for a plan for group nursing. (Group nursing and general duty nursing under the case assignment method are identical.)

Obtaining data to serve as a basis for group nursing, and the planning of personnel for group nursing are parts of the course in Ward Administration.

DAY PICTURE OF PNEUMONIA ROUTINE, MEN'S MEDICAL WARD

A. M.

7.30 Night report.
Offer bedpans and urinals.
Wash and refill water pitchers and cups with ice water.

8.00 Serve breakfast and feed all patients. Care for mouths before and after meals. (Faces and hands have been washed by the night nurse.) Give q. i. d. medications and record on patients' charts.

8.30 Daily normal salt enema to all patients with T. 102.6 degrees F. (rectal), and to others who have not had a defecation within 24 hours.
Care of enema equipment.

9.00 Start baths. (Care for the patients in rotation; care for sickest patients first.)
Change linen; make beds.
Force fluids as work progresses.
Supply patients with clean paper bags and napkins.

10.00 Give t. i. d. medication and record.
Offer urinals to patients.

11.00 Baths and bed-making finished.
Refill water pitchers.
Force fluids.
Change solution in hand basins; supply with clean towels.
Place in order room and cupboard; supply and refill solution bottles as necessary.
Care of soiled linen.

11.30 Serve dinner and feed all patients. Care for mouths before and after meals.

NOON

12.00 Give t. i. d. medications and record.
Take 6-hour rectal temperatures, pulse and respiration.
Offer bedpans and urinals to patients.

P. M.

12.30 Give Sherman's vaccine hypodermically to patients with rectal temperature over 99.6 degrees F.
Chart symptoms and care given.

1.30 Offer bedpans and urinals.
Refill water pitchers.
Force fluids.
Give liquid nourishments.
Start therapeutic sponges for patients with T. 102.6 degrees F. (rectal). (Care for patients in same rotation as at 9 a. m.) Force fluids as work progresses.

2.00 Give t. i. d. medications and record.

3.00 Start giving afternoon care. (Afternoon care consists of bathing face, neck, hands, arms and back; applying alcohol and powder to back; adjusting bed covers and pillows for general comfort of the patient; and cleansing the mouth.)

4.00 Give q. i. d. medications and record.

4.30 Refill water pitchers and supply clean paper bags and napkins to bedsides.
Change solution in hand basins.

5.00 Serve supper and feed all patients. Care for mouths before and after meals.

5.30 Offer bedpans and urinals.
Maintain general room order and resupply equipment in cupboards as necessary.

TIME STUDY OF THE NURSING CARE GIVEN TO SIX PNEUMONIA PATIENTS

Procedure	No. Times Repeated in 24 Hrs.	Av. Length of Time Required for Procedure	Total Time Required Daily	Total Time Required for 6 Patients
Basic		Minutes	Minutes	Minutes
Care of mouth	8	2	16	96
Feeding of patients	3	15	45	270
Liquid nourishment	3	2	6	36
Forcing of fluids	6	2	12	72
Refilling pitchers with ice water	8	4	32	32
Baths, including supplying with paper bags	1	30	30	180
Therapeutic sponge	3	30 (½ of no. of patients)	90	270
T. P. R. (rectally), q. 6 hrs.	4	5	20	120
Changing hand solution	5	4	20	20
Re-supplying equipment and general housekeeping	3	15	45	45
Bedpans and urinals—estimated q. 2 hrs.	12	2	24	144
Recording of symptoms and care given	4	3	12	72
Special				
N. S. S. enema	1	16 (½ of no. of patients)	16	48
Q. I. D. and T. I. D. Medications; q. 4-hr. Medications	9	2	18	108
Routine hypodermics	4	5	20	120

Total: 1,633 minutes per day for routine care of six pneumonia patients.
1633 x 7 = 11,431 minutes for care of six pneumonia patients for one week.
51 x 60 = 3,060 minutes of nursing service given by a general duty nurse per week.

6.00 Give t. i. d. medications and record.
Take 6-hour temperature, pulse and respiration.
Give Sherman's vaccine hypodermically to patients with rectal temperature over 99.6 degrees F.
Chart symptoms and care given.
7.00 Offer bedpans and urinals.
Refill water pitchers.
Force fluids.
Give therapeutic sponges for T. 102.6 degrees F. (rectal). (Care for patients in rotation as at 9 a. m.)
8.00 Serve liquid nourishment.
Give q. i. d. medications and record.
8.30 Give evening care to patients not receiving therapeutic sponges.
Cleanse mouths, and supply clean paper bags and napkins.
Force fluids as work progresses.
10.00 Change solution in hand basins.
Record symptoms and care given.
11.30 Offer bedpans and urinals.
MIDNIGHT
12.00 Give q. 4 hr. medications and record.
Take 6-hr. T.P.R. and record.
Give Sherman's vaccine hypodermically to all patients with rectal temperature over 99.6 degrees F.
Refill water pitchers.
Force fluids.
A. M.
1.00 Serve liquid nourishment.
Start therapeutic sponges for patients

with T. 102.6 degrees F. (rectal). (Care for patients in same rotation as at 9 a. m.)

3.00 Offer bedpans and urinals.
Refill water pitchers and force fluids.

4.00 Give q. 4-hr. medications and record.

5.30 Offer urinals.
Give morning care. (Morning care here consists of bathing face and hands, cleansing the mouth and adjusting bed covers and pillows for comfort of the patient.)
Re-supply clean paper bags and napkins, refill water pitchers.
Force fluids.
Change solution in hand basins, supply clean towels, and place in order room and cupboard.

6.00 Take 6-hr. temperature, pulse and respiration.

6.30 Give Sherman's vaccine hypodermically to all patients with rectal temperatures over 99.6 degrees F.
Offer bedpans and urinals.

7.00 Record symptoms and care given.

Therapeutic sponges need not be given directly after temperatures have been taken. They are not given to reduce temperature, but for the sedative effect.

Temperature, pulse and respiration are taken every six hours with this group of patients, because the Sherman's vaccine is used as a part of the treatment. The Sherman's vaccine is given to pneumonia patients whose temperatures are over 99.6 degrees F., every six hours.

This picture does not include any emergency orders that arise with crisis or efforts made with delirious patients.

Much more care could be added if a larger personnel for the group is to be considered. Such care would include more frequent changing of patient's position, forcing of fluids in smaller amounts and feeding the patient until he is further on the road to recovery.

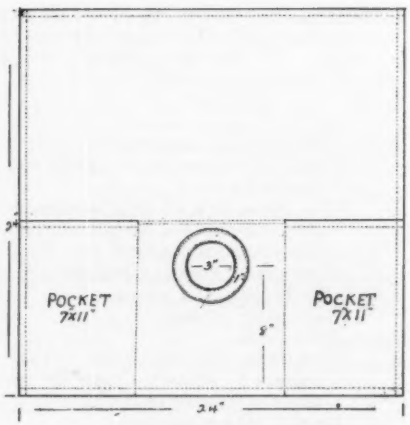
A Circumcision Sheet

NELL C. BOHANNON, R.N.

PLACE the baby on the table, remove the diaper and fasten the gown around the arms with a safety-pin.

Standing at the baby's head, open the sterile circumcision sheet. Slip your hands into the pockets of the sheet and grasp the baby's feet so they will not come in contact with the sterile field of operation.

The lifting of the hands will throw the upper part of the sheet over your arms and the baby. Adjust the opening in the sheet, which gives ample space for the field of operation, and you will then find that you have the lower part of the sheet providing a sterile field for instruments and dressings.



CIRCUMCISION SHEET

Savings and Investments

How One Organization Assists Its Staff To Save

WINIFRED L. FITZPATRICK, R.N.

DO nurses as a group save money? is a question often asked. Nurses are like every other group of women. Some are natural-born savers, some were taught to save in their childhood, some have learned the value of saving through sad experience and some others have not yet learned the lesson. This latter group consists largely of the young graduates and there is no group more enthusiastic or interested in saving when encouragement and a plan for saving is presented to them.

Once each year, in November or December, the Providence District Nursing Association devotes the entire time of one staff meeting to the consideration of the value of Savings and Investments.

The object of the meeting is to stimulate in each nurse the formation of the habit of regular saving. The discussion is led by the Director and is in the form of a friendly chat on the importance of regular and systematic saving by every individual with some objective in view. The objective may be a trousseau, a trip abroad, a post-graduate course, the purchase of a home or a fur coat, the creation of an estate for one's dependents or provision for one's old age.

Efforts are made to interest the young staff nurse in annuities, by pointing out how cheaply they can be purchased while one is still in the twenties. It is much easier, however, to get the young nurse to save for the project nearer at hand.

Budget-keeping is recommended as the first step in the savings plan, and the very simplest monthly and yearly forms are presented and explained.

The various methods of saving money are discussed in the following order: (1) savings bank, (2) insurance, (3) building and loan associations, (4) stocks and bonds.

The Providence District Nursing Association has been fortunate in having on its Board of Managers men and women who are associated with the best saving institutions and organizations in the city and who are always willing to confer with the nurses and advise them about their investments.

1. *Savings Banks.* To stimulate the young nurse to start a savings account, the Association offers to deduct from her monthly salary any amount she may elect to save, no matter how small, and make the deposit for her. One Board member, the president of a savings bank, arranges to send a messenger each month to the District Nursing office to collect the deposit, when notified that it is ready, returning the books to the office when the bank has made the necessary entries. The plan in Providence is individual, not a group plan, each nurse making her own decision as to whether she wishes to save in this way, and if so, how much. The name of the nurse is on the outside of the pass book and it is kept in the safe at Association headquarters. It is her private property while there and is never looked at by any other person; she may call for it as often as she chooses.

If a nurse does not wish to have her savings deducted from her salary, she may have her deposit made through the office, to save time in going, herself, to the bank. A list of nurses having deduction and the amount

thereof is given to the bookkeeping department each month, and one check covering the entire amount is sent to the bank with the pass books. In 1928, $4,383 were deposited for thirty nurses. From time to time the bank books are passed around to their owners and seem to contain many happy surprises for them in the amount accumulated; apparently they had not realized the rate at which savings grow when kept up systematically.

Another form of savings and one gaining in popularity is that known as the club method. Inaugurated by savings banks some years ago, as Christmas clubs, and later as vacation clubs, several banks now advertise them as special purpose clubs. Several of the staff nurses carry from one to four clubs, maturing at intervals throughout the year, to be used as the new name implies, for special purposes. It may be for Christmas, a vacation, a special purchase, or the payment of an insurance premium. The club plan consists of a weekly deposit of any regular amount, from fifty cents to five dollars and earns interest at the rate of 4 per cent. Deductions for club payments are also made from salary and are sent to the bank monthly with the deposit.

2. *Insurance.* Previous to the staff meeting at which saving is to be discussed, information from representatives of several insurance companies is obtained and explained to the nurses. This information covers various types of policies, such as a *straight life* policy for the nurse who has dependents and desires to create an estate, *endowment* policies maturing in fifteen, twenty or thirty years, and *annuity* policies that provide a regular income for the nurse when she reaches the retiring age. Many endowment and annuity policies contain clauses providing for disability, and all such policies have a collateral loan value. *Sickness insurance*, providing a weekly indemnity in case of illness or accident, is carried by ten of the staff. The premiums on this insurance are also collected at the District Nursing office and sent to the insurance company.

3. *Building and Loan Associations*, sometimes known as coöperative savings banks, are a popular form of saving. From time to time advice from some qualified member of the Board of Managers is secured on the standing of these organizations.

4. *Stocks and Bonds.* Expert advice on investments, especially in stocks and bonds, is available for every nurse in Rhode Island and can probably be obtained by the nurses in every other state. Investment officers in some of the banks in Providence have addressed various meetings of nurses on the subject and have invited any nurse to call on them at any time for free advice.

Each year, following the yearly discussion of saving at the Providence District Nursing Association, several new savers are added to the list, and these are usually the new staff nurses who have been appointed within the year.

Last year a young nurse who had been on duty but a few months started a savings account of $5 per month. At the end of her first year she received her automatic increase of $10 per month. She came to the Director and asked that this increase be deducted in addition to the $5 already being deposited, saying: "I have lived for a year on my present salary and have purchased two new coats during that time, and if I have managed it for one year, I guess I can continue to do so." This nurse had never previously saved.

As the habit of systematic saving is the first step to financial independence,

it would seem that encouraging results had been achieved by at least one group in Providence as shown by the following table:

A study of savings among sixty-two staff nurses showed:

	59 Saving regularly
	3 Not saving
METHODS	
Banks:	39 Savings
	25 Clubs (Christmas and special purpose)
Insurance:	13 Straight life
	34 Endowment
	1 Annuity
	12 Sickness
Building and loan:	21
Stocks and bonds:	9
Number saving by one or more methods:	
1 method	9
2 methods	20
3 methods	19
4 methods	7
5 methods	4

The total savings of the 59 nurses, as represented above, for the year 1928, amounted to over $14,000.

An Obstacle

CHARLOTTE PERKINS GILMAN

I was climbing up a mountain path
With many things to do,
Important business of my own,
And other people's too,
When I ran against a Prejudice
That quite cut off the view.

My work was such as could not wait,
My path quite clearly showed,
My strength and time were limited,
I carried quite a load;
And there that hulking Prejudice
Sat all across the road.

So I spoke to him politely,
For he was huge and high,
And begged that he would move a bit
And let me travel by.
He smiled, but as for moving!—
He didn't even try.

* * * * *

I took my hat, I took my stick,
My load I settled fair,
I approached that awful incubus
With an absent-minded air—
And I walked directly through him,
As if he wasn't there!

—*From "In This Our World."*

The "Nationalen Bond"

A New Nurses' Association in Holland

"ON January 1, 1929, Nosokomos will go to sleep, all activities will stop, and the new Board will have the privilege of using its documents and records. If all goes well, Nosokomos will have gone out of existence by January 1, 1930; otherwise it will take up its old activities again."

Thus quietly do the Dutch nurses announce an event which is epochal not only in the history of nursing organization in Holland but, by implication, in the history of nursing throughout the world.

In Holland, land of sturdy individualism, there have been many nurses' organizations. The announcement that Nosokomos is deliberately being "put to sleep" by those who have loved and struggled for that organization which is a member of the International Council of Nurses, is startling news.

As far back as 1890, a Dutch Board of Nursing was organized with a mixed membership of lay and professional persons, but it was in 1900 that Nosokomos erected the first Dutch Nurses' Association with the aid of Dr. Aletrino and his wife, a former nurse. The Nutting and Dock History of Nursing and other sources have familiarized American nurses with the names of Jane van Lanschot Hubrecht, M. Berkelback v. d. Sprenkel, M. Verwey Mejan and, more recently, that of Meta Kehrer, whose forceful personality impressed those who attended the meetings in Helsingfors. Devotedly have these, and others like them, worked to strengthen and increase the influence of Nosokomos, through which a curriculum was formulated, entrance requirements were increased, the standards of examination were raised and state registration fostered. It has encouraged sound education for members of public health nursing staffs and for the faculties of schools of nursing. In short, Nosokomos has worked diligently to improve the education of nurses in Holland.

The newly erected National Board is handicapped by Nosokomos, because only one national organization in a country may belong to the International Council of Nurses. Nosokomos, always hoping and working for one mighty board or organization of nurses, and seeing more possibilities for growth for the new Board than for herself, is willing now to step aside and to give the younger organization, which is founded on the *same principles*, a real chance.

The spirit of Nosokomos was well expressed by Miss Kehrer, its Chairman, in the official organ of the association for November 10, as follows:

> We have to come, and we will come, to an independent, self-reliant organization of all nurses. What can we do in order to attain our purpose? If we cannot reach it with the small group of those who until now tried to reach the goal, let us see that, in that case, from our small group radiates a strong moral influence to the new organization, helping and supporting those who strive after the same goal, setting our shoulders under the same task which is worth our utmost effort.

Nursing in Holland has a bright future, when such steadfast women see clearly that a cause is greater than any mechanism set up to serve it. "Putting Nosokomos to sleep" is an extraordinarily courageous act. May its justification lie in the immediate future, and the new organization be found eligible for membership in the International Council of Nurses, thus replacing Nosokomos.

The Rectal Dumb-bell

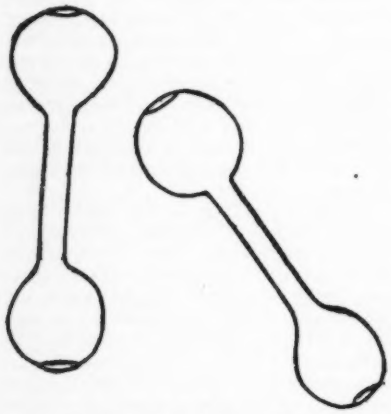
ROSE NEWMAN, R.N.

Purpose

The function of the rectal dumb-bell is to aid in the expulsion of gas from the bowel.

Appearance

The dumb-bell, as the term implies, consists of two bells of hollow glass attached to a glass bar. One bell may be slightly smaller than the other, but



DUMB-BELLS—ACTUAL SIZE

in many instances they are of the same size. The dumb-bell is made of good quality glass and is about 2½ to 3 inches in length. In appearance it is not unlike the dumb-bell used in gymnasiums.

Indications for use

In any condition where distention with gas causes discomfort. It is used principally, however, for the post-operative abdominal patient. It should be used early. While we know that true gas pains usually appear 36–48 hours after operation, there may be some accumulation of gas earlier and the dumb-bell will aid in the expelling of this gas.

Procedure

1. *Position.*—The patient may be in any position. However, the post-operative patient is usually in the dorsal recumbent position.

2. *Protection for foundation bed.*—Place a bed pad under the patient. (This may be made by using a foundation of newspaper—one sheet of newspaper folded in quarters—upon which are placed the odds and ends of absorbent cotton and gauze left from surgical dressings or a layer of cellucotton and a layer of crude cotton over which is stretched one thickness of gauze secured in place with large stitches. Some hospitals use the oakum pad which was so popular during the World War.) The rectum almost always contains some liquid feces. This will be expelled with the flatus and will be absorbed into the pad, thereby saving the foundation bed.

3. *To insert.*—Lubricate the smaller of the two bells being careful not to cover the opening with vaseline. *Have the patient breathe through the mouth.* Hold the dumb-bell in your right hand—spread the patient's knees apart and insert one bell only, being careful to face the opening of the unlubricated bell toward the pad. (Gas being held under pressure will shoot in all directions when released and may prove rather disastrous to both the nurse and the surroundings.)

Note

A. There is no stated length of time for the dumb-bell to remain in the rectum. The important point to remember in the post-operative patient is to use it early. Later it may be used for 30–45 minutes, several times, or whenever it is indicated for distention.

B. It has never been recorded that the dumb-bell has slipped up into the rectum. However, if the patient is apprehensive or if the dumb-bell is new to the nurse using it, an ordinary piece of string may be tied to the bar leaving 8–10 inches. This string may be fastened to the patient's thigh with a strip of adhesive tape.

C. Neither has it ever been known to break while in the rectum. Seemingly the buttocks act as a cushion of protection.

D. *Have the patient breathe through the mouth* while removing the dumb-bell also. There is a strong suction or pull in the alimentary tract which is released upon opening the mouth. If this suggestion is not followed, the patient will experience considerable pain while the dumb-bell is being removed.

E. It is hoped that more nurses will try this little device, since it has been found to be most satisfactory to the comfort of the patient over a period of observation of six to seven years. The dumb-bell is manufactured by the Milwaukee Glass Company and comes in three sizes. The price is nominal.

Nursing in Iceland

THE beginning of modern nursing in Iceland was brought about by the fight against leprosy. Professor Ehlers, of Copenhagen, spent the years 1894–95 in Iceland studying conditions connected with this disease. The Leper House built in the seventeenth century had been abandoned in the nineteenth. Lepers now lived in their own homes among the healthy members of their families and few, if any, precautions were taken to isolate them. As a result of Professor Ehler's discoveries, a recommendation was made to the government that strict isolation should be enforced and that a special hospital should be built to which admission should be compulsory for all lepers, so long as there was room. . . . Eventually the Danish Freemasons opened a subscription list, and a leper hospital was built in Iceland. In the deed of gift it was laid down as one of the conditions that the hospital should employ a Danish trained nurse. This was the dawn of Icelandic nursing, but a number of years were yet to elapse before the first Icelandic nurse was trained, and during that time the Danish nurse in the Leper Hospital was the only trained nurse in Iceland. In 1907 the first and only mental hospital was built. In 1912 the first tuberculosis sanatorium was opened; and the second, in 1927. In the western part of the island, the most modern county hospital was dedicated in 1925, and now has accommodation for fifty patients. In Reykjavik, the capital, the State Hospital is being built. This will be connected with schools for the medical, nursing and midwifery professions in the island. . . . As things are in Iceland at present, nurses cannot complete their training in the country, but must take an affiliated training in surgical and obstetrical nursing, as well as in communicable diseases, in Denmark or Norway, where they must sit for their final examinations.

In 1920 a small group of Icelandic nurses, together with a few Danish colleagues who were living in Iceland, united to form the Icelandic Nurses' Association, with a modest membership of twelve. At the present time the Association has thirty-seven active members and twenty-three associate members, the latter group being made up of student nurses. Last summer the Association had the great honor and pleasure of welcoming colleagues from countries of Northern Europe on the occasion of the Annual Executive Committee Meeting of the Nurses' Union of Northern Europe, which was held in Reykjavik.

In the autumn of 1925 the president of the Icelandic Nurses' Association was appointed to sit on the Grand Council of the International Council of Nurses, as Associate National Representative for Iceland. This was a step of the utmost significance for the Association because, isolated as it is, it fully appreciates the great support it will mean to be in close touch with nurses of other nations. The Icelandic Nurses' Association stands firm for a three years' course of training, and indeed, many of its members are of the opinion that all Icelandic nurses ought to take an additional six months' training in prophylactic work, since it is hoped, in the not too distant future, to have a fully trained nurse available for every country district in Iceland.—Excerpts from "Nursing in Iceland,"—*The I. C. N.*, April, 1928.

Not *Our* School?

THE Grading Committee says that each year more graduates of training schools are entering the nursing profession than can be adequately cared for. In its chapter on "The Hospital and the School," in "Nurses, Patients, and Pocketbooks," Dr. Burgess points out that the frequently suggested, easy solution for this difficulty, "abolish all the small schools," will not work. "This would not solve the problem," she says, "because

1. There are some small schools which are producing high-grade nurses. Smallness in itself is not an educational crime.
2. Most graduates do not come from small schools. They come from large ones.

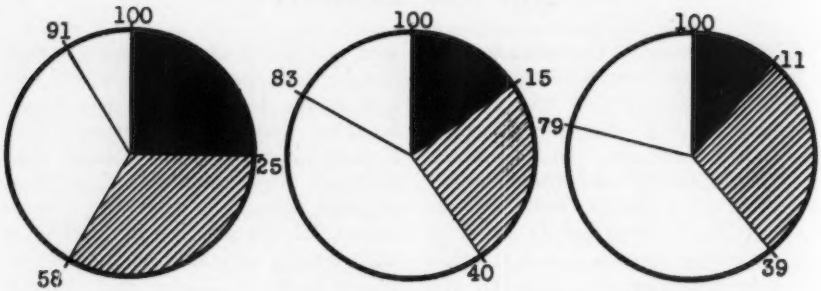
The quickest way to curtail production would be to *begin at the top.*"

But, says the hospital administrator who is in charge of a famous nursing school: "Although the Grading Committee tells us that there are too many graduates each year, it also states that many of those graduates are inadequately prepared for nursing, in that they have not had a solid educational foundation." In industry, today, candidates for positions as file clerks, typists, stenographers, saleswomen in department stores, etc., are, in increasing numbers, being required to present a high school diploma before industry will take them in. The Grading Committee is saying, "Is it not as important to have a reasonably sound educational preparation in nursing as it is in the clerical positions of industry?" There seems to be rather a convincing argument for raising the requirements for entrance to the nursing profession to include at least high school graduation for all candidates.

"In the light of these findings," says the administrator of the big hospital, "is it not clear that elimination or curtailment of student nurses should begin in the small school and not in the large? Is it not true," he asks, "that the large schools have already almost uniformly raised their entrance requirements to four years of high school, so that the schools responsible for flooding the profession with poorly educated young women belong to the smaller groups? Should not attention be concentrated upon those schools instead of upon the larger ones who are already upholding good educational standards?"

In the diagram which accompanies this article there are three circles; giving information for nurses who have entered the profession *within the past five years.* This group of nurses is chosen because they represent the most recent tendencies in nursing education. The first circle shows graduates from schools connected with hospitals which had a daily average of less than 100 patients. The second is for graduates from schools connected with hospitals which had a daily average of from 100 to 500 patients; and the third for nurse graduates from hospitals with a daily average of 500 or more patients. In each circle the black portion represents the per cent of these recent graduates who have had one year of high school or less; the shaded portion, those who have had two or three years of high school but dropped out before finishing; the first white section the per cent who have finished high school; and the second white section the per cent who have had some college work.

It will be seen that the hospital administrator is right when he suggests that small hospitals are graduating a larger percentage of high school failures than are the medium or large hospitals. Yet the diagram furnishes



Per cent of nurses graduated within the past five years, from small, medium, and large hospitals, who had one year of high school or less (black); 2 or 3 years of high school (shaded); 4 years of high school (first white section); or one or more years of college (second white section).

convincing evidence that if the records gathered by the Grading Committee hold true for all recent additions to the profession, the larger hospitals are by no means free from responsibility. In both the medium and the large groups practically 40 per cent of the recent graduates consist of these under-educated women who would not be admitted into the clerical positions in industry.

The diagram raises an interesting question. If the standards for admission to nursing schools are to be raised, what action will be taken by the schools in these three groups? Will they attempt to enroll just as many students as before, but make sure that all of them are high school graduates? If that action is taken, and if the hospitals succeed in getting a sufficient number of applicants, as it is possible they may, we shall then have a profession with higher educational standards, but growing far faster than the general population. Over-production would appear to continue as a serious menace.

It is true that there are many unfilled positions at the top of the nursing profession. Yet the actual numbers of such positions which now exist with salaries attached, so that nurses properly trained could go immediately into them, is impressive only because of the importance of the work. Instructors, for example, are needed, and needed badly, but the actual number is comparatively few. With 20,000 new nurses coming into the profession this year, the fraction who could go into teaching, were they prepared to do so, is very small.

To what extent is the mere raising of educational standards sufficient to safeguard the profession?

If nurses continue coming into the profession each year at the rapidly increasing rates which hold at present, even though they be highly skilled, well-educated women, is there any assurance that there will be work enough for them to do? If not, the problem would seem to be one not only of raising standards, but of actually limiting the output as well. If instead of merely raising entrance requirements, the hospitals would consider reducing their present output by the per cent of students who in the diagram are represented by the black or shaded areas, might they not be contributing more towards the economic safety of the profession?

Editorials

The "Journal" in '29

FROM the combined offices at "370" the editors and the staff of the *Journal* extend their wishes for happiness and prosperity in the New Year to all nurses.

This is not merely a formal wish. It is heartfelt. It is supported by active effort, for the editors believe that plans in the making for 1929 will provide *Journal* readers with more specific assistance with professional problems than ever before. For example, some time ago the placement bureau of the American Hospital Association announced that "hundreds of applications for various positions in the hospital organization were received, the vast majority of which were made by applicants who were unfitted by experience and training for the positions to which they aspired." Following this, the *Journal* began a study of the available hospital postgraduate courses. It is planned to publish the results of this study early in the year in the hope that the findings may be useful to many ambitious nurses. Most of the postgraduate courses in Universities are advertised constantly in the *Journal*, and the many summer courses will, as usual, be announced in one of the spring numbers.

A very real effort will be made throughout the year to provide more material than in the past on actual nursing procedure. A number of highly qualified instructors have already pledged their support to this program. This emphasis on nursing, in contradistinction to nursing activities, vitally important though they are, will be brought out by our series of "Eminent Teachers" which will replace the "Who's Who" of the past few years. The *Journal* welcomes this opportunity to honor some of the modest women who have left an imperishable impress on the lives and service of nurses.

It is possible to plan for the new year in a more spacious fashion than ever before, because the *Journal* reflects the size and quality of the profession itself. With more than 70,000 members in the American Nurses' Association and others on the edge, as it were, of joining through the membership campaign soon to be launched, the *Journal* is more strongly entrenched in the life of the profession and the social life of our time than ever before.

In 1929

LAST January almost a score of prominent nurses expressed, through the *Journal*, their belief that community understanding is essential in solving some of the problems of nursing and that the promotion of such understanding should be made a major aim of the profession in 1928. What has been accomplished in the year just gone? The Committee on the Grading of Nursing Schools has published "Nurses, Patients and Pocketbooks," and almost 4,000 copies of the book have been sold, an appreciable number of them to members of Boards of Directors and other interested citizens.

At the same time the Committee on the Cost of Medical Care, of which Dr. Ray Lyman Wilbur of Stanford University is Chairman, and which has a membership of over forty persons, doctors, economists, nurses, and social workers, has been at work, and although it has not yet made any specific studies of nursing, it is obvious that the economics of nursing will sooner or later enter into the picture. Both of these national committees consider a program of publicity an essential part of their plans. It is obvious, therefore, that through these and through means set up by the national nursing organizations, we may expect the work of "informing the public" to go on.

What then shall be our aim for 1929? The attitudes of schools of nursing toward the work of the Grading Committee are reminiscent of the children who heard the school bell begin to ring when they were still some distance away. Said one "Let's kneel down and pray that we'll get there on time"; said the other "Let's run!" Some of the schools are obviously already running. Many are equally obviously hoping and waiting for some divine or other supernatural aid to come to their rescue.

Those that may be said to be running are doing the logical thing. They are looking to the quality of their nursing, for there lies the answer to the Grading of Schools of Nursing. The test of a teaching method, and this includes careful assignment of nurses to patients, lies in the quality of nursing service, for good nursing cannot be taught where good nursing is not done.

This is no time for complacence. The complacent, if such there be, run serious risk of discovering that the world, the nursing world, has moved on beyond them. Here, there, and yonder, schools of nursing are studying themselves. They are scrutinizing the qualifications of their faculty members. They are encouraging the able, but not yet fully qualified ones, to secure postgraduate courses by granting leaves of absence and by the use of scholarships. They are studying the intricate problems of correlation of theory and practice. They are making time studies to determine the kinds and amounts of care needed for particular groups of patients, they are analyzing costs. They are studying the difficulties, psychological, physical, and other, of caring for particular groups of patients, such as respiratory and cardiac cases. Where does it all lead? It means that, when the first grading is accomplished, some schools will inevitably outclass others.

Schools of nursing are means, not ends. They exist to teach nurses to care for patients and it may be said that, in a scientific sense, good care of patients is the aim of the nursing profession in 1929, for we are searching for facts, we are studying, analyzing our methods. This is no new aim in nursing. It is the scientific approach which is new. Nursing procedures must stand the test of analysis. They must be adequate. They must be as simple as possible in order that they may be economical of time, effort and material. They must be therapeutically safe and effective. They must aim to give physical and mental comfort to the patient.

Just as there are schools of nursing which far exceed the requirements of state boards of nurse examiners, and some which teach an even richer curriculum than that outlined by the National League of Nursing Education, so there are schools which are already thoughtfully working on the problem which is the crux of the work

of the Grading Committee: "What is adequate nursing service and how may it be secured?" The best of these schools carefully hold fast to the traditional "love of folks" that lies at the very heart of nursing. No amount of science can produce good nursing if it tends to reduce it to a factory system which ignores the individual differences in patients. Such schools are to be emulated for their attention is focused on the true goal of nursing, the safety, comfort and happiness of the actual and the potential patient.

Untilled Fields in Nursing

SOME years ago Professor Winslow of Yale made an address which has become a classic in the literature of Public Health. It is called "The Untilled Fields of Public Health." As we move across the threshold of a new year we are mindful of the untilled fields in nursing. Hundreds of nurses are said to be waiting in our cities for private duty cases. At the same time we know that in every state in the Union there are patients suffering from tuberculosis and patients mentally ill who are not receiving anything that approximates good nursing service. We believe, too, that many patients of moderate means are receiving far less than adequate nursing care. Furthermore, the picture of rural conditions in Missouri, painted by Miss Stebbins, is unfortunately true of many states. Our rural areas are not adequately nursed.

Probably a few of the waiting nurses are incompetent and cannot hope to be successful in any field. Many of them, however, would do well to look to some of the untilled fields. To be sure, these fields require energy, initiative, and good preparation. Hourly nursing, group nursing, and graduate floor duty, are not fields for incompetents but for well qualified, skilful nurses. Tuberculosis and psychiatry are needing women of high type who can take the initiative in formulating and expanding nursing programs. Nursing in the country requires personal gifts and skill of a high order.

These things are in part problems of distribution. We shall look to our expanding registries for leadership and for evaluation of local opportunity. They are, in part, a matter of preparation. It seems very clear that more and more nurses should look to postgraduate courses if they would seek opportunity in the untilled fields. Unless the country is scourged by an epidemic, or unless there is a general exodus into the untilled fields, the ranks of private duty nursing will tend to remain overfull, with consequent unhappiness of many nurses. It is time to look to the untilled fields for the very real professional opportunities that lie within them, for they should be made to yield substantial satisfaction in economically and socially rewarding professional opportunity.

At the I. C. N. in Montreal

EITHER of two things may happen in Montreal when the I. C. N. meets there in July, and the nurses of the United States of America must choose which it shall be.

The American Nurses' Association is the largest organization of nurses in the world, much larger than that of Canada, the hostess organization. We are Canada's next door neighbors, whereas the delegates from all other countries must make long, sometimes difficult and all of them expensive journeys in order to attend. With our numbers, our proximity, and best of all our keen interest in international affairs, it is assumed that we shall have

a very large delegation at Montreal. Because of our very size the Montreal meeting will not have the flavor of true internationalism that made the Helsingfors meeting so delightful, unless we of the United States of America help to make it possible by subordinating ourselves. Genuine helpfulness may well take the form of self-effacement.

The Canadian nurses are the hostesses and Canada is a sister nation. Shall we, as American nurses, resolve to do our utmost to keep the delightfully cosmopolitan atmosphere of the I. C. N. by subordinating ourselves wherever possible? Shall we go to Montreal strongly imbued with the idea of helping the nurses from other countries to get the very most out of the meetings? It would be a gracious act if we Americans should deliberately plan to "take back seats" wherever possible, leaving the more desirable locations to those who have travelled farther, and in particular to those who will have more or less serious language difficulties. If we do not, our overwhelming numbers will tend to give a predominantly American flavor to the meetings which even the most Chauvinistic would not desire since we have abundant opportunity for self-expression at our own biennials.

The thought is not original with the *Journal.* It originated with a nurse who plans to drive to Montreal and who has already notified the friends who will accompany her that, once in Montreal, her car will not be at their disposal, but will be made available for nurses from other lands for the duration of the meetings, and for a period of touring afterward.

The arduous labor of planning for the Congress falls wholly upon the gallant Canadian nurses. They are fully able and buoyantly willing to perform it. They are preparing a royal welcome for us and for the nurses from all the other countries. Shall we highly resolve, unobtrusively, to help them make the Congress a brilliant and satisfying international success? Self-effacement is said not to be a characteristic of our nation, but it is a characteristic of nurses. Shall we practice it at Montreal?

PROGRESS, then, must be through the group process. Progress implies respect for the creative process, not the created thing; the created thing is forever and forever being left behind us. The greatest blow to a hidebound conservatism would be the understanding that life is creative at every moment. What the hard-shelled conservative always forgets is that what he really admires in the past are those very moments when men have strongly and rudely broken with tradition, burst bonds, and created something. True conservatism and true progressivism are not two opposites: conservatives dislike "change," yet they as well as progressives want to grow; progressives dislike to "stand pat," yet they as well as conservatives want to preserve what is good in the present. But conservatives often make the mistake of thinking they can go on living on their spiritual capital; progressives are often too prone not to fund their capital at all.—From "The New State," by M. P. Follett.

Eminent Teachers

Annabelle McCrae, R.N.

Edited at Massachusetts General Hospital

As full-time instructor, Miss McCrae has taught the Principles and Practice of Nursing to one thousand, four hundred and ninety young women, seventy of whom have themselves become full-time instructors. Her teaching has been still further extended by her book, "Procedures in Nursing," which was published in 1923.

It is a simple task to outline Miss McCrae's activities. It is not so simple to explain why she is one of the greatest teachers of nursing that the profession has known. What qualities does she possess that enable her to start off these students of hers with a momentum that many of them never lose? Why is it that her form rises before her students registering accusation or disappointment when they have allowed themselves to fall below their best? On such occasions they may think of her probable words of chastisement, but more clearly they think of those days in the classroom where she constantly set them the example of her own best. They recall the example of a teacher who never clung to old ideas, but was always changing her methods to meet new situations. They remember teaching that was characterized by concrete knowledge and a craftsmanship that carried with it the finish of an artist; teaching characterized by a spirit and a dramatic power that gave life to the subject and fire to the student. Miss McCrae teaches the theory of nursing with its technic, and what is important, she preaches and practices that principle of Friederike Fliedner's: "The soul of service must not be sacrificed to the technic."

ANNABELLE MCCRAE

One of her graduates writes of her:

> She was able to determine the capacity and individual differences of each student and challenging the ability that she found in us, she relentlessly held us to our best. As students we often resented this. As graduates we cherish it. Thus did she prepare and steel

us for the responsible duties before us. Thus she developed in us qualities of self-control, self-reliance, courage and initiative. She also developed in us a loyalty for and a pride in the vocation which we had chosen.

Miss McCrae was born in the province of Quebec; she is of Highland Scotch parentage; she was educated in public and private schools. In 1891 she came to the United States to enter the McLean Hospital Training School for Nurses, from which she was graduated in 1893, and where she remained for six months as a head nurse. Miss McCrae then entered the Massachusetts General Hospital Training School for Nurses, graduating in 1895, and during the following seven years was assistant superintendent at the Quincy Hospital.

In 1902 the school at the Massachusetts General Hospital was reorganized and Miss McCrae was appointed part-time instructor and assistant to Miss Dolliver, the superintendent of the school. In 1912 she was made full-time instructor in nursing and she is still holding that important position, teaching with the vigor and energy which is so characteristic of her work.

In the summer of 1926 Miss McCrae attended Teachers College, New York; in 1925 she took the course in Psychology of Teaching, given by the State Department of Education; and in 1926 took the course in Principles of Methods of Teaching in Secondary Schools, at Boston University.

Miss McCrae was a charter member of the Massachusetts State Nurses' Association, and Chairman of its Census Committee. She has been Secretary and Treasurer of the Massachusetts League of Nursing Education, and for eight years President of the Sick Relief Association of her Alumnae. During the summer of 1918 she was released for service in the Army School of Nursing at Camp Devens where she taught nursing.

Miss McCrae's pupils, working throughout the length and breadth of the land, acknowledge an unmeasurable personal and professional debt to her. They well know that the only coin in which she desires or accepts payment of this debt is in the coin of a high standard for their own personal and professional life. Because of Miss McCrae's example as a woman, a nurse, and a teacher, hundreds of her graduates have earnestly endeavored to pay her their debt of honor.

New Year's Day

ALL our years are made up of days; and all our days are but little parts of years.

For each man it is his own birthday that tells him how many years of days he has had.

For mankind it is New Year's Day, which Charles Lamb called the nativity of our common Adam.

For each of us how many failures, disappointments, losses!

Yet God has pulled us through, and we have still a chance to do better.

The race goes on, indomitable, hopeful. It is a day for repentance and patience and courage. Yes, please God!

For unless we resolve to be good, the world will never be better.

—*Henry van Dyke.*

Used as a nurses' message by the Guild of St. Barnabas for Nurses, edited by Rev. C. T. Walkley, D.D.

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY LAURA R. LOGAN, R.N.

Future of Schools of Nursing[1]

In the Light of the Grading Committee's Report

ADDA ELDREDGE, R.N.

THE "Report of Nursing and Nursing Education in the United States," the study made by the Committee for the Study of Nursing Education in the United States and published by that Committee in 1923, variously known under the titles, "The Rockefeller Report" or "The Goldmark Report," brought out many of the weaknesses in schools of nursing. This report, however, dealt with but twenty-three schools and included, as is stated in the report, a disproportionate number of good schools.

Only a few of the facts brought out in that report will be touched upon here, and those, we believe, with many others have had an enormous effect on nursing education and have brought many changes in our institutions and much improvement in the preparation of teachers, in teaching, and in equipment for teaching. To quote from the report:

> The nurse, in the vast majority of cases, still receives her professional training not in an educational institution independently endowed and organized, as Florence Nightingale conceived it, but in a training school which is a part of a hospital and responsible for furnishing its nursing service. Such a school shares inevitably the essential weakness of the apprentice system; its first liability is service—production, not education. Only within a comparatively short time has the teaching of nursing been in any degree differentiated from apprenticeship, and been placed in part on a sounder educational basis, providing that balance of practical experience and didactic teaching which is the desideratum in all vocational preparation.

To quote again:

> The Dual Function of the Training School—On entering upon a study of nurse training today we are confronted by this dual character of the training school. It is indeed, as we shall see, the crux of our problem, the heart of our difficulty. For the school of nursing has sought to perform two functions: to educate nurses and to supply the nursing service for the hospital. But in these two functions there lies an ever present possibility of conflict. The needs of training and of hospital services may not coincide, and when the two are in conflict, the needs of the sick must predominate; the needs of education must yield. Whether or not, for instance, a student nurse has completed the services required for her training, whether or not she has had experience with children or has had sufficient instruction in medical disease, if surgical patients are in need of care, to the surgical ward she is sent, though she may already have exceeded the time set for this service.

After showing how some of these things can be met, the report goes on to say:

> We must first illustrate concretely how the training of nurses is sacrificed and prolonged in deference to the needs of the hospital. Today this cardinal point is unheeded, unrecognized, but the bar to progress at present lies precisely in ignorance of the facts. No action will follow until these facts sharply

[1] Read at the annual meeting of the Illinois League of Nursing Education, Joliet, Ill., October 12, 1928.

challenge the interest of those in authority; that is, first the responsible hospital trustees and, behind them, the general public on whose financial support either directly through gifts or indirectly through taxation, the hospitals are dependent.

While the Rockefeller Report brought help and constructive criticism to those in charge of schools of nursing, it did not make a profound impression upon the medical profession and the public which this later study (1927) by the Grading Committee makes upon all who read it. The facts as to supply and demand, the showing beyond question that we are producing more nurses than the public can be persuaded or can afford to use; the facts as to the economics of private duty nursing, into which 54 per cent of our graduates go; the fact that the many and fine and wonderful nurses in the private duty field have to compete with the poorly educated, poorly trained graduates of the poor schools and even of the good ones, and who are more or less barred from the other fields, as well as the unchangingly low earnings of the average private duty nurse, or to quote from the report—

Three things are wrong with private duty:

1. There is an overproduction of nurses. This results in unemployment problems which are especially acute in the private duty field, since the field must absorb all workers who cannot secure either public health or institutional positions.

2. Private duty is a free-lance occupation open to all comers. Good nurses suffer from the competition of women far below their level in breeding and intelligence, professional ethics, and nursing knowledge and skill.

3. The free-lance worker in nursing, as in other professions, inevitably pays for her cherished independence of action through lowered income, irregular employment, and extreme professional loneliness.

Then again, to briefly touch upon the faults in public health brought out in the report, these are that there is no lack of applicants, but that there is a lack of applicants with public health experience or public health training, a lack of proper bedside technic, and an unwillingness to accept supervision.

Also, what is the matter in the production field, or the hospitals? Schools are too small to provide proper experience. Nurse superintendents of both hospitals and schools have had little experience. There is a lack of education of the nurse superintendents of hospitals. That of those having been out of training ten years or less shows that 23 per cent have never been beyond the first year of high school, and the report says:

How can they satisfactorily solve the problems of hospital administration with such a limited background? Six per cent of the superintendents of nurses and 9 per cent of those holding the dual position who have been graduated less than ten years have never had more than one year of high school, and one-half of the superintendents of both have had no special preparation, either in hospital management or in educational methods.

Almost two-fifths of all superintendents of nurses have held their present position one year or less. They, the superintendents of nurses, change their positions more frequently than those who hold both positions and than the superintendents of hospitals, which statement is pregnant with meaning. Another pregnant statement is that the average superintendent of nurses attended only three out of a possible twelve meetings of her board of trustees in 1927, and the report asks if this lack of connection with the board of trustees does not explain some of the frequent changes. We quote from the report:

Most hospitals with training schools expect and require the student nurse to carry the

entire nursing load of the hospital. Sixty-seven per cent of the schools conducted by superintendents of nurses and 83 per cent of those conducted by superintendents of both services report that not a single general duty graduate nurse is employed in their hospitals. Approximately half of the schools conducted by superintendents of nurses and two-thirds of those conducted by superintendents of hospitals and nurses have either no R.N. teacher or only one. The number of supervisors or head nurses is governed in a large measure by the number of students in the school. For schools of both types there is an average of nine students for every supervisor or head nurse. Of every 100 superintendents of nurses, 24 prefer graduate nurses for the care of patients, and 76 prefer student nurses! They would rather train new students than utilize their own finished product. While extra nurses for general floor duty are often needed, superintendents of nurses have not the funds to engage them in time of stress. Moreover, although it pays a higher rate than private duty, general floor duty is unpopular among nurses. Until hospitals are able to make general duty really respectable in the eyes of the nursing profession, they will always find it difficult to persuade high grade nurses to work for them in that capacity.

It is impossible to talk of the needs of the schools and the future of the schools without considering the fields which are to be supplied. In all lines of work the nurses want what every other worker wants—reasonable hours, adequate income, constructive leadership, and professional growth. We all know that this can only be had by working together as a unit, and by bearing in mind that there would be no reason for the profession of nursing were it not for the patients.

We also know that the statement that many patients are not getting the care they need is true. Most of us know of the vast number of hospitals which are being inadequately nursed by people under the misleading terms of "undergraduate" or "practical nurse," the former generally meaning dismissed students and the latter a most impractical person without training.

That our superintendents are willing to state that they are unwilling to employ the product which they turn out is the severest criticism that can be made of the work being done in our schools. Certainly if our graduates cease to be of any use after they cease to be students, there is something radically wrong with the method of their training. The majority of boards of trustees, many superintendents of hospitals, and even some superintendents of nurses, look on student nurses as an economic asset to the hospital. Not long since, in conversation with an instructor in a school of nursing, I was told that the student nurses had to be taught to wash out the linens in the operating department because they could not get maids who were willing to do it. I did not succeed in convincing this instructor that she had the wrong point of view.

In the report there is strongly brought out the fact that practically all superintendents of nurses are administrators first and foremost, while they have slight acquaintance with the modern educational philosophy and methods and are conducting their schools much along the lines they themselves were taught years ago and, I may add, *defending their position* in the light of the *educational value* to the students of those worn-out methods. One of the great troubles with the graduate staff, and one of the reasons the superintendent does not like it as well, is that she wants to treat them as if they were students.

It has been necessary to quote some of the above facts to give us a basis for the discussion of what we are to do, and to shape the future of our schools of nursing in the light of these facts.

The first thing that I would say is, do nothing hastily, nothing without

study and investigation. There is very little in the Grading Committee's report that is at all new or strange to anyone who has been working with schools of nursing for any length of time. Nothing is going to happen abruptly, and nothing can be more foolish than hasty, unwise action.

I believe the second thing that I would recommend is to find out why your institution is running a school of nursing in connection with its hospital. Is it because the board of trustees feels that they have an imperative duty to run a school, because of the facilities which their institution has to offer, because of the clinical material it contains, or because of the community needs? I advise a good deal of reading of the Grading Committee's report before a decision on this point is arrived at.

If it is decided that there is a valid reason for the existence of the school, let us run over some of the things necessary for a school, to see if you possess them. Is your board able and willing to provide the students with proper housing and recreational facilities? Are they willing to provide the expense of proper laboratories, properly equipped, of classrooms and demonstration rooms? Are they willing to look upon the students as students, and not as an economic asset?

My advice is, do not raise all schools immediately to a high-school standard, for remember that with a high-school requirement you must be able to give instruction beyond the high school, *i. e.*, of college grade. If the students are to carry work of college grade, the teaching too must be of college grade, which means the superintendent of nurses, the instructor, and the supervisors must each have had preparation for her job, and cannot be the recently graduated nurses from their own school who have had no further preparation.

We also must make sure that the physicians who lecture are teachers, and must not ask them to lecture simply because they are on the staff. They should be selected because they are interested in education and willing to prepare each day's lecture as thoroughly as any college professor must prepare his lectures.

Is it the time for us to raise the age of entrance? Johns Hopkins is able to insist upon twenty-one years. We should ask for high-school graduates and let that be the minimum, not by force of law but by cultivating a desire upon the part of those responsible for this standard. Each student should have a physical examination, and elimination should come before time has been wasted on the teaching of useless material, or the young women have wasted their time and health in a vain effort. Mental examinations or tests should be given, not with a view to elimination of students but with the idea of helping the student and showing justice towards her. Careful study of previous high school records should be made, special information gained on the student's connection and place in the high school, whether in the upper, middle or lower third of the class, what her reaction is to group activities. If possible, have a personal interview. Ask for a letter or paper on a given subject, which will enable you to judge her English, spelling, handwriting, and powers of expression. Some inkling may be gained of her background even through the kind of paper she uses. Elimination should begin before the applicant enters, and only in rare cases should students be retained who fail in the first or preliminary semester.

Schools of nursing should begin to

require certain studies as prerequisites. It has been suggested that Physiology is difficult because of a lack of preparation in Chemistry and Physics. A certain scholarship should be required, as well as certain motor abilities. After the student has been admitted, one of the most important things is the length of the working day. Hours on duty are of immense importance when we consider an educational program. We nurses are congratulating ourselves today because the majority of schools of nursing have an eight-hour day, or at least a fifty-six-hour week, forgetting quite that no student is on an eight-hour day if she works eight hours over her patients, besides carrying from two to four hours of class and laboratory work. Yet we all know that each hour of class should require two hours of preparation, one hour and a half being an irreducible minimum, and then where, oh where, is that eight-hour day? I believe I am correct in stating that Yale and the University of Wisconsin have a six-hour day, but from reports, even an eight-hour day is not the rule in all states.

Recreation is an important factor in nursing schools, and we need prepared people as recreational directors, and here again we should insist on preparation, for a woman who is to act in this capacity needs a very broad background of education and culture. The next question is, How can we do all this? Already we know that a patient has twenty-four hours in which he must be cared for, and with an eight-hour day that means, at the least, two and one-half nurses to a patient. Here I will answer three questions in one—stabilize your nursing service in each hospital by the employment of graduate nurses, and then you can immediately eliminate or cut down the number of student nurses entering. You thus provide employment for some of the surplus graduates, and you guarantee your patients continuous and expert nursing care, while giving to your students time for class and study without that evil accompaniment of the knowledge that the patient suffers through her class, and the sense that she and her education are of more importance than the patient.

It might be advisable to state here that it seems doubtful if, in the years to come, schools of nursing will be conducted in connection with hospitals which have not a segregated nursing service. One of the most difficult problems today, even with a segregated nursing service, is to have that connection between the theory and the practice which is so necessary if every student is to feel that all her class work centers in the health of the patient, either as prevention or care. This is especially important because the theory in the curriculum should be tied up as closely as possible to the care of the patient. If we can give medical service at the time that medical lectures are given, if the study of the patient ill with pneumonia can be accompanied by classroom study with a review of the anatomy of the lungs, the normal physiology of the lungs, shown with the changes produced by the pneumococci (Bacteriology), the nutritional changes explained through the normal to the abnormal, the drugs used in connection with the particular patient (Materia Medica), the nursing procedures demonstrated with the results expected and the results achieved—in other words the why, when and how. If, in addition, she knows that John Smith is a bookkeeper with a salary of $1,500 per year who has a wife and two small children and an aged mother to support, and

no relatives to help him, and that he is facing a problem of debt, in addition to the pneumonia, what a much more interesting problem to the student nurse, especially if she knows what the social service worker plans for his future—possibly at a convalescent home, and that his wife is being helped to keep the family going. There is little danger that Jane Jones, student nurse caring for John Smith, will not be interested in her patients or will not endeavor to be a good enough bedside nurse to be well worth while as a general duty nurse in the hospital, and willing to try to be a living example to the students of what knowledge, a keen interest and finished nursing mean to the sick. But how can a student nurse with unrelated class work, working on a floor under a fellow classmate with no more knowledge than she has, gain the above connection? Today many of our students begin their training by cleaning lavatories, and are promoted to answering bells, to giving baths, later to giving medicines and taking temperatures, and then to doing dressings, knowing many of her patients by the numbers of their rooms only, and feeling many times that bathing patients, making them comfortable and doing the necessary things in nursing are work for the Junior nurses. How can a nurse so trained be particularly interested in John Smith and connect him with his temperature, his dressing, and his bath, when her knowledge is totally unconnected with the manner of man he is, or why he isn't happy, though doing well?

Can the above give us some idea of how, in an effort to get more work done—to be more efficient—we have quite forgotten many educational precepts?

A subject that should occupy our attention for a little is, have we all the clinical material in our institutions which nurses need? There is, I believe, no doubt that we need what we call the four basic services—medical, surgical, obstetrical and pediatric training—but then, too, there are tremendous calls for nurses who have been well trained in communicable disease nursing, the care of mental and nervous patients; our tuberculosis sanatoria are needing nurses; no nurse is really prepared who has no knowledge of public health. Nurses need to be taught more about improvising, and caring for patients away from the conveniences of the modern, up-to-date hospital.

The schools connected with small hospitals are not the only ones without medical and pediatric training. An analysis made of the four basic services show two of the largest hospitals with less than 10 per cent medical patients during 1927, and two of the smallest with an average of 35 per cent and 41.7 per cent, and two hospitals, having pediatric departments, had a trifle over 8 per cent in that department, which certainly shows the fallacy of judging the experience in a hospital as having any relation to size. It would seem that if we are to meet the conditions for an educational institution, at least the last year should be used for affiliations in those services lacking in the institution, and this without regard to that very poor guide—size or bed-capacity—but with exact relation to the average clinical material, the clinical material which is to serve to teach her and that the number of students should be determined on the same basis, a proper ratio being maintained by graduate nurses, to ensure proper care to the patient.

A very necessary point in our teaching is the need for teaching students

to work with all modern equipment, but that in the Senior year they should demonstrate how they would do these same things in well- or poorly-equipped homes, without losing the essential things in aseptic surgical or medical technic showing that she does understand the underlying principles, which enable her to keep her proper technic under totally different conditions and without any of the equipment she ordinarily would use.

To summarize:

1. A careful determination of the reason for having a school of nursing.
2. A superintendent of the hospital with an appreciation of the school as an educational entity.
3. Careful selection of a school of nursing committee or board—and giving this board power to act.
4. Determine on a budget for the school, based on sound educational principles.
5. The selection of a fully prepared superintendent of nurses with power to engage her faculty, and with an open door between her and the board, as well as her committee.
6. Careful selection of the faculty by the superintendent of nurses after and with conference with the board of the school.
7. Arrangements for staff education and promotion, as at present we cannot find enough prepared women.
8. A careful study of clinical material, and a determination of the number of students who can be properly educated with this material.
9. Arrangements for affiliation for the subjects missing. Certain places might devote themselves to giving these affiliations, based on the same careful study.
10. Careful selection of students, based on character and previous education, physical and mental examination.
11. Careful preparation of students, and elimination; special help given to those needing it.

    The establishment of student councils, student government or some form of student coöperation or participation.
12. Elimination of schools not able to properly function, and the curtailment of the establishment of unnecessary new schools.
13. Stabilizing nursing service with carefully chosen graduates on floor duty, impressing them with their responsibility for upholding standards, and that their position is one of high honor.
14. Careful education of board of trustees and school committee, until they see the educational side and are willing, themselves, to work to educate the community as to the need for financial support.
15. Making it worth while for a good superintendent of nurses to stay in a school.
16. Frequent faculty conferences, studying not only graduate but student needs.
17. Monthly reports to the board, read by and discussed with the superintendent of nurses, showing needs as well as accomplishments.
18. Preparation of requirements for those occupying positions in the school, not static but frequently revised.
19. Not less than high school graduation for faculty as well as students.

    Special preparation for all those in positions on the faculty, with a gradual requirement of postgraduate study—this provided for through leave of absence, scholarships, loan funds, etc., though we might take a leaf out of the teachers' requirements, which call for certain advanced study within a given time, with assurance of a salary increase if the results of this study give increased efficiency.

In other words the answer to what shall be the future of our schools is that those which develop on educational lines will continue; those which deny the facts presented by the Grading Committee and refuse to act will eventually die out.

I would like to close this very inadequate discussion with the following quotation from the Grading Committee's report:

> The result of the demonstrated value of students, however, is that hospitals will naturally hesitate to change from a student system which gives good service to a graduate system with which they have had no real experience. Most hospitals feel that they would much prefer to have their students rather than graduates to take care of their patients. This is partly because it is cheaper

to run a poor school than to pay graduate salaries.

Even in cases where the schools are genuinely good, and therefore expensive, most superintendents of nurses would prefer to continue with student service.

This means that the fight to demonstrate the superiority of *trained* nurses in bedside care is not yet won. There is something wrong with a viewpoint which prefers the services of partially trained women to those who have finished training.

Perhaps the chief reason for preferring students to graduates is that students will accept without complaint conditions which graduate nurses will not tolerate.

Superintendents making these suggestions believe that they call not so much for the expenditure of money as for intelligent sympathy and a modern viewpoint. They point out that

1. Decreased turnover will partly offset salary increases.

2. Increased size of staff and improved quality of floor duty will mean the reduction in the use of specials. The regular hospital charge to patients might be increased if patients knew that they did not need to employ special nurses.

3. The reduction in the number of specials would be offset, from the nurses' viewpoint, by the greater and more attractive opportunity for nurses in general duty.

4. Superintendents make these recommendations believing that the change from wholly student service to wholly or partly graduate service would, in the long run, be more satisfactory for the patient, less expensive for the hospital than running a really good school, better for the future of the nursing profession, and more satisfying to the superintendent of nurses.

Having offered no strikingly new suggestions on the subject of schools of nursing, it is hard to avoid your conclusion that one has not answered the question involved in the title "Future of Schools of Nursing in the Light of the Grading Committee's Report," and still we need to do little more with our schools than to eliminate the poor ones, to strengthen the good ones, to educate boards, hospital superintendents, physicians, and the taxpayer to the fact that the education of nurses is as much the concern of the public as of nurses, and then to honestly continue our plans for student education on the research plan, only unhampered by students kept to do the work, graduates employed because we have graduated them, faculty selected with the idea that they will follow instructions, but doing it all as we know it should be done—for the benefit of the sick and the prevention of disease, and to prepare the nurse.

It would be wise to postpone any suggestions for changes in the curriculum until we hear what the Grading Committee learns about "What Nurses Need To Know and How They Need To Be Taught," and to await without fear the actual grading of schools of nursing.

Schools of Nursing with University Connections

APPROXIMATELY one hundred schools of nursing have some sort of connection with a college or university and there is every reason to suppose that this movement will continue. In view of this situation, the sale of the "Proceedings" of the Conference on Nursing Schools connected with Colleges and Universities, held in New York City last year, is surprisingly small.

The report is extremely valuable. The very fact that, on many points, it is suggestive rather than conclusive is indicative of its importance. The Proceedings may be obtained from the National League of Nursing Education, 370 Seventh Avenue, New York City. Price, $1.

A Time Study

A Study of the Hours of Nursing Service Needed and Hours of Nursing Service Given in an Infant Section of a Pediatric Ward of the Cook County Hospital

WITH INTRODUCTION AND COMMENT BY GLADYS SELLEW, R.N.

THE following study was made by Mrs. Anna Parks, a graduate student of the Illinois Training School for Nurses. It illustrates a method of forming a plan for the nursing of a unit in a large hospital.

The "day picture" or daily routine is that followed in an infant section of the Children's Building of Cook County Hospital. The time study was made by Mrs. Parks in the summer of 1928. The time slip is that of a representative day; the functional method of assignment being used.

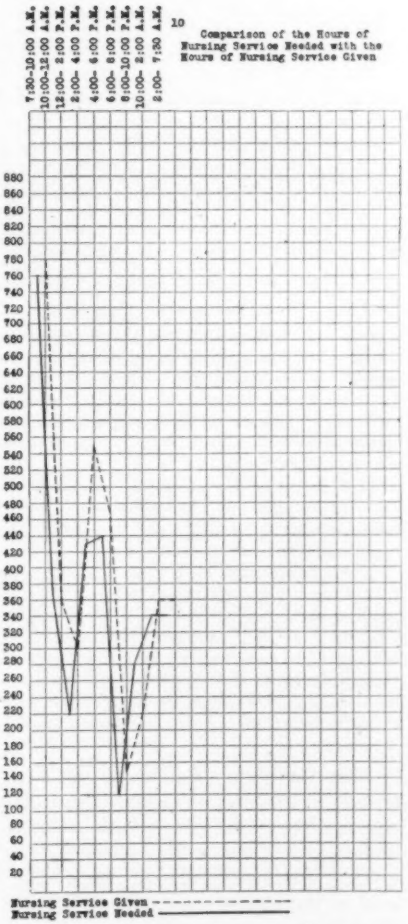
Aseptic technic was not used as a routine measure. The ward is divided into rooms, containing not over six cubicles, and any infant developing signs of an infectious disease is cared for with strict aseptic nursing technic.

The graph and its explanatory chart show the minutes of nursing care required at various periods of the day. This is, of course, computed by using the time required for various procedures as given in the day picture.

In the graph, the black, continuous line represents the minutes of nursing service required. By using the time slip, the minutes of nursing service given at the same periods was ascertained and is shown by the broken line.

It will be noted that at only one point does the broken line fall below the continuous line.

The final check-up of the work would naturally be the improvement in the condition of the infants. These cases were all feeding cases, so that the gain in weight is a fair test. The following chart shows the gain in



COMPARISON OF THE HOURS OF NURSING SERVICE NEEDED WITH THE HOURS OF NURSING SERVICE GIVEN

COMPARATIVE WEIGHTS OF 20 INFANTS OVER A ONE-WEEK PERIOD

No.	Lbs.	Oz.	Lbs.	Oz.	No.	Lbs.	Oz.	Lbs.	Oz.
1	7	7	7	10	11	9	4	9	7
2	7	1	7		12	8	15½	9	4
3	10	9	10	13	13	7	2	8	6½
4	9	2	10	8	14	9	11½	9	15
5	5	13	6	11	15	7	3	7	4
6	5	11½	5	10½	16	9	5	9	10
7	8	13½	9	9	17	9		9	
8	8		8	2	18	7	2	7	11
9	12	4	12	1	19	13	1	13	
10	7	10	8	1	20	6	8	6	6

weight of the infant. It must be remembered that Cook County Hospital receives acutely sick cases, and does not care for infants that no longer urgently demand hospital care. The students in the class of Ward Administration of the Illinois Training School for Nurses are asked to make studies of this type, either of

1. Actual ward conditions, showing the use of the hours of nursing service given on the ward and suggesting what adjustment could be made in the work of the ward if the ratio between the hours of service given and the hours of service needed by each patient were decreased or increased.

2. A group of a type of patient, as of six pneumonia cases, and having shown what is necessary to their care, to plan a schedule for group nursing.

3. An imaginary ward, planning day picture, time study, required number of hours of nursing service, required number of nurses, time on duty and assignment. The minutes of nursing service required by the patients in this study must closely correspond with the minutes of service given by the nursing body at each period of the day, as shown on the time slip.

This study is of a small division, twenty beds, of a 75-bed children's ward. The supervisor of the medical pediatric service is in charge of the work. The head nurse of the unit, as well as the instructors, works with the students.

The difference in time spent on each infant in this study, as compared with that given in a time study made at the Babies' and Children's Hospital of Cleveland, illustrates the additional time required by the use of aseptic nursing technic and the amount of nursing service required to carry out the orders of the physicians in a hospital where much research work is done.

INFANT DAY PICTURE OR DAILY ROUTINE

A. M.

7.30–9 Bathe and weigh infant. (All infants must be weighed before being fed.)

8 (a) Offer infants three ounces of water. Give cod-liver oil, orange juice and q. 4-hour and t. i. d. medicines to infants as ordered.

(b) Take temperatures of infants on a q. 4-hour schedule. (If possible, do this at time of bathing.)

9 (a) Give q. 3-hour and q. i. d. medicines to infants as ordered.

(b) Give feedings to infants on a q. 3-hour feeding schedule. If cereal or other food is ordered, give before the bottle.

10 (a) Give feedings to infants on a q. 4-hour feeding schedule. If cereal or other food is ordered, give before the bottle.

(b) Change all infants' diapers.

12 (a) Give feedings to infants on a q. 3-hour feeding schedule.

(b) Take temperature of infants on a q. 4-hour schedule.

(c) Change all infants' diapers.

(d) Give q. 4-hour and q. 3-hour, q. i. d. and t. i. d. medicines to infants as ordered.

P. M.

2 (a) Give feedings to infants on a q. 4-hour feeding schedule. If purée or other food is ordered, give before the bottle.

(b) Change all infants' diapers.

3 (a) Give feedings to infants on a q. 3-hour feeding schedule. If purée or other

food is ordered, give before the bottle.
(b) Give q. 3-hour medicines to infants as ordered.

4 (a) Offer infants three ounces of water. Give cod-liver oil, orange juice and q. 4-hour and t. i. d. and q. i. d. medicines to infants as ordered.
(b) Take temperatures of all infants.
(c) Change all infants' diapers.

6 (a) Give feedings to infants on a q. 3-hour and q. 4-hour feeding schedule. If cereal or other food is ordered, give before the bottle.
(b) Give q. 3-hour and q. i. d. medicines to infants as ordered.
(c) Change all infants' diapers.

8 (a) Give q. 4-hour and q. i. d. medicines as ordered.
(b) Take temperatures of infants on a q. 4-hour feeding schedule.
(c) Change diapers of infants fed.

10 (a) Give feedings to infants on a q. 4-hour feeding schedule.
(b) Change diapers of infants fed.

MIDNIGHT

12 (a) Give feedings to infants on a q. 3-hour feeding schedule.
(b) Give q. 3-hour and q. 4-hour medicines as ordered.
(c) Take temperatures of all infants on a q. 4-hour schedule.
(d) Change all infants' diapers.

A. M.

2 (a) Give feedings to infants who are to receive six bottles in twenty-four hours.
(b) Change diapers of infants fed.
(c) Give q. 3-hour medicines as ordered.

4 Change all infants' diapers.

6 (a) Give feedings to infants on q. 3-hour and q. 4-hour feeding schedules.
(b) Take temperature of all infants.
(c) Change diapers of all infants.
(d) Give q. 3-hour medicines as ordered.

NOTE.—This schedule is subject to additions and variations as ordered by physician. If infant cries, see if his diaper is dry. Change diaper when necessary.

Infants may be given water at night if there is reason to believe they desire it.

Special treatments are given

b. i. d. ..... 10 a. m.–4 p. m.
t. i. d. ..... 10 a. m.–2 p. m.–6 p. m.
q. i. d. ..... 8 a. m.–12 noon–4 p. m.–8 p. m.

unless otherwise ordered.

The personnel of the unit is:

Day Duty

Head nurse.
Two postgraduates.
Four students.
Two of these spend 3 hours in the milk laboratory.
Two of these spend 2 hours in the preparation of food in the diet kitchen.
Postgraduate dietitian.
1½ hours feeding infants in morning.

Relief

Student, 2–6.30–11 p. m.
Attendant, 8–11 p. m.

Night

Student 11 p. m.–7.30 a. m.
Attendant, 1–2, 5–6 a. m.

Head nurse	7.30–12.30, 2.30–5.30
Instructor	7.30–8.30
Dietitian graduate student	7.30–8.30
Nurse graduate student	7.30–12, 12.30–4 (class 9–10, 4–5)
" " "	7.30–12.30, 1–3.30 (milk lab. 9–10, class 3–4)
" " "	7.30–12, 12.30–3 (infant diet 10–12)
Student nurse	7.30–12.30, 3.30–6.30 (milk lab. 9–12)
" "	7.30–1 half day (infant diet 10–12)
" "	7.30–12, 5–6.30
" "	2–6, 6.30–11
" "	11–7.30
Attendant	8–11 p. m.
"	1–2, 5–6 a. m.

7.30–9 a. m. Part of head nurse's time spent instructing nurses and checking up on condition of infants. Morning conferences, etc., held for all students, take up part of this period.

TIME STUDY OF HOURS NURSING SERVICE NEEDED BY THE AVERAGE PATIENT IN THE INFANT DIVISION OF CHILDREN'S MEDICAL WARD, COOK COUNTY HOSPITAL

Aseptic nursing technic is not used

Procedures	Number Time in 24 Hours	Average Length Time	Total Time in 24 Hours
1. Weighing	1	3	3
2. Bathing	1	5	5
3. Bed-making	1	4	4
4. Diaper-changing	12	3	36
5. Holding Water	2	5	10
6. Temperature-taking	3	3.2	9.6
7. Charting	1	5	5
8. Medication (orange juice, cod-liver oil)	2	1.2	2.4
9. Bottle-feeding	5	11	55
10. Cereal, purée, etc.	3	6	18
Special Care			
1. Hot dressings 2. Dry dressings 3. Ear wicks 4. Eye irrigations 5. Mouth irrigations	1 av. for group	10	10
6. Heliotherapy	1	6	6
7. Assisting doctors	1	4	4
			60/168.0
			2.8

ILLUSTRATION OF HOW THE MINUTES OF NURSING SERVICE FOR ANY GIVEN PERIOD OF THE DAY ARE COMPUTED

Hour	Procedure	Time Required for 1 Infant (Minutes)	Time Required for 20 Infants (Minutes)
7.30–10 a. m.	Weighing	3	60
	Bathing	5	100
	Bed-making	4	80
	Giving of water and holding	5	100
	q. 3-hour Feedings	11	110 (10 infants on q. 3-hour schedule)
	Medications C. L. O. O. J.	1.2	24
	Temperatures	3.2	64
	Cereals	6	60 (10 infants have cereal)
	q. 4-hour Feedings	11	110 (10 infants on q. 3-hour schedule)
	Changing diapers	3	60
			768

Some interesting points were noted: Babies taking a prescribed formula at 2 o'clock, at the rate of seven minutes per baby, required an average of 13–15 minutes to consume the same amount at 6 o'clock. This was partly explained by the fact that purée preceded some of the 2 o'clock feedings, while cereal preceded the same feedings before 6 o'clock. Also, cod-liver oil, orange juice, etc., were not given between the 10 o'clock and 2 o'clock feedings, while cod-liver oil, orange juice and water were given between the 2 o'clock and the 6 o'clock feedings.

Other interesting features were: Since work for a large group must keep the essential elements that make the individual patient gain, and at the same time be arranged to make possible the care of the whole group on a minimum number of nurses, the infants are fed in rotation, each infant having his fixed place in the list. (Thus the interval ordered by the physician is maintained though the feeding of the group extends over an hour, or even more.)

The work is planned to have the procedure finished by the time given in the day picture. For instance, all 9 o'clock feeding must be finished by 9 a. m.

Right

WE are evolving now a system of ethics which has three conceptions in regard to right, conscience and duty which are different from much of our former ethical teaching: (1) We do not follow right; we create right; (2) There is no private conscience; (3) My duty is never to "others" but to the whole.

First, we do not follow right, merely; we create right. It is often thought vaguely that our ideals are all there, shining and splendid, and we have only to apply them. But the truth is that *we have to create our ideals.* No ideal is worth while which does not grow from our actual life. Some people seem to keep their ideals all carefully packed away from dust and air, but arranged alphabetically so that they can get at them quickly in need. But we can never take out a past ideal for a present need. The ideal which is to be used for our life must come out from that very life itself. The only way our past ideals can help us is in molding the life which produces the present ideal: we have no further use for them. But we do not discard them: we have built them into the present—we have used them up as the cocoon is used up in making the silk. It has been sometimes taught that, given the same situation, the individual must repeat the same behavior. But the situation is never the same, the individual is never the same; such a conception has nothing to do with life. We cannot do our duty in the old sense, that is of following a crystallized ideal, because our duty is new at every moment.

Moreover, the knowledge of what is due the whole is revealed within the life of the whole. This is above everything else what a progressive ethics must teach—not faithfulness to duty merely, but faithfulness to the life which evolves duty. Indeed "following our duty" often means mental and moral atrophy. Man cannot live by tabus; that means stagnation. But as one tabu after another is disappearing, the call is upon us deliberately to build our own moral life. Our ethical sense will surely starve on predigested food. It is we, by our acts, who progressively construct the moral universe; to follow some preconceived body of law—that is not for responsible moral beings. In so far as we obey old standards without interpenetrating them with the actual world, we are abdicating our creative power. . . .

You cannot hang your ideals up on pegs and take down Number 2 for certain emergencies and Number 4 for others. *The true test of our morality is not the rigidity with which we adhere to standard, but the loyalty we show to the life which constructs standards.* The test of our morality is whether we are living, not to follow but to create ideals, whether we are pouring our life into our visions only to receive it back with its miraculous enhancement for new uses."—From "The New State," by M. P. Follett.

Our Contributors

The authoritative article on the International Council of Nurses by its President, **Nina D. Gage, M.A., R.N.,** is an important contribution to the literature of our profession. Of deep interest to graduate nurses, it will be welcomed also by students of the history of nursing.

Ruth M. Klotz, R.N., is Instructor at the Grant Hospital School of Nursing, Columbus, Ohio.

Herbert E. Coe, M.D., and **Virginia Boyer, B.S., R.N.,** collaborated in their article on Cleft Lips and Cleft Palates while Miss Boyer was still at the Children's Orthopedic Hospital in Seattle. She is now instructor in the school of the Chicago Memorial Hospital.

Marion Burns, R.N., is Supervisor of the Surgical wards at the Children's Hospital of Boston, having both administrative and teaching duties including bedside clinics.

Few people could write as intimately of rural Missouri as does **Mary E. Stebbins, R.N.,** for she has penetrated even the most remote sections of the state in her work with the Extension Department of the University of Missouri. We publish the article for its intrinsic value, and to remind nurses of our vast un-nursed areas and of the importance of really surveying and knowing a field before attempting to plan a nursing service for it.

We are indebted to the *Journal of the American Medical Association* for permission to reprint the practical little article by **Frank H. Lahey, M.D.**

Thyra E. Pedersen, R.N., is Assistant Superintendent of Nurses, U. S. Veterans' Bureau, a steadily growing service which now employs more than 2,000 nurses and provides very satisfactory salaries and living conditions.

Anne Slattery, R.N., knows well the field of nursing education in Canada, for she is a valued member of the faculty of the School for Graduate Nurses at McGill University, Montreal. The article was prepared by her for the Canadian Nurses' Association Committee on Publicity.

As Head Nurse and as Instructor in Nursing at Willard Parker Hospital, New York, **Mary Dinneen, R.N.,** who is a graduate of the Brooklyn Hospital School of Nursing, has had excellent opportunity for exercising her ingenuity in developing nursing technics.

Mildred McCormick, R.N., who made the drawings for Miss Dinneen's article, is a supervisor at the same interesting institution.

The article by **Etta S. Hall, R.N.,** who is a Supervisor of Group Nursing at West Suburban Hospital, Chicago, is a valuable addition to the increasing volume of proof of the worth of group nursing.

Dr. John M. Swan, who is Chairman of the New York State Committee of the American Society for the Control of Cancer, prepared the bibliography on Cancer at the suggestion of Mary F. Laird, R.N., representative of the New York State Nurses' Association on that Committee.

As the Director of Nursing and Public Health service for the Commonwealth Fund, **Alma C. Haupt, B.A., R.N.,** has had extraordinary opportunity for study of rural needs.

Carolyn E. Gray, M.A., R.N., consultant in nursing education, might well have called her penetrating article, "Do their catalogues really reflect the schools they represent?"

Mrs. Nell C. Bohannon, R.N., is Supervisor of the Obstetrical department at the Jewish Hospital, Cincinnati, Ohio.

The article on Savings and Investments was prepared by **Winifred Fitzpatrick, R.N.,** Associate Director of the Providence Visiting Nurse Association, as part of her contribution to the Insurance Committee of the American Nurses' Association.

We are indebted to **Miss H. Melk,** now on leave from her position in the Municipal Hospital at The Hague to study at Teachers College, New York, for the data on nursing activities in Holland.

Rose Newman, R.N., is Instructor in Practical Nursing at Mount Sinai Hospital School of Nursing, Milwaukee, Wisconsin.

Adda Eldredge's discussion of the Future of Schools of Nursing indicates the importance of looking to the qualifications of the faculties of these schools.

The *Journal* welcomed the Time Studies of **Gladys Sellew, M.A., R.N.,** for only by scientific analysis of nursing procedure can we hope to answer the questions, "What *is* adequate care, and how may it be obtained?"

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Meeting of Advisory Committee of the Veterans' Bureau

THAT the Veterans' Bureau is desirous of securing the very best medical and nursing care of its ex-service men and women is evidenced by the creation of a Medical Advisory Committee and an Advisory Committee of Nurses, which were appointed some years ago. Both committees met on November 12, 13 and 14. The following members of the Advisory Committee of Nurses were present: Clara D. Noyes, Chairman, Lucy Minnigerode, Harriet Bailey, J. Beatrice Bowman, Adda Eldredge, Elizabeth Fox, Laura R. Logan, Alice Stewart, Julia C. Stimson.

At the Request of the Director, General Hines, Miss Logan visited Maywood General Hospital in Chicago, Illinois; Miss Stewart visited Aspinwall, a tuberculosis hospital near Pittsburgh, Pennsylvania, and Miss Bailey visited a psychiatric Hospital in the Bronx, New York. All reported upon the efficiency of the nursing service and the excellent care that ex-service men were being given. Considerable time was spent on the consideration of special postgraduate courses for nurses employed by the Veterans' Bureau. Several members of the Committee remained, after the regular meetings, in order to help develop outlines for the course.

Follow-up work of tuberculosis patients in their homes by public health nurses was also the subject of a special resolution which was presented to the Medical Board, urging that the original policy of follow-up work by public health nurses to patients suffering with tuberculosis be continued. As there are 11,000 ex-service tuberculous persons in their homes reporting to the Regional Office and in need of this particular type of nursing service, a well-trained group of public health nurses is certainly indicated.

A committee from the Medical Advisory Committee to study postgraduate work, personnel, etc., was appointed upon which Miss Logan represents the Advisory Committee of Nurses.

Nurses will be interested to learn that approximately 2,000 nurses are employed in the Veterans' Bureau Nursing Service, probably the largest staff of nurses employed by any one organization in the world.

Meeting of National Committee on Red Cross Nursing Service

THE National Committee on Red Cross Nursing Service held its annual meeting on December 11. The Annual Meeting of the American Red Cross was held on the 12th, making it possible for many members of the National Committee to remain over for this event. The program contained the following subjects for consideration:

1. Methods for increasing enrollment in order to meet the present demand for nurses for disaster work and other Red Cross Nursing activities.
2. Active, non-resident and associate membership in alumnae associations, and its effect upon Red Cross enrollment.
3. (a) Instructions for supervising nurses in disasters.

(b) Instructions for local committees in disasters.

4. What the future holds for public health nursing under the American Red Cross.
5. Information for Chapter Nursing Activities Committee or Home Hygiene Committee, etc.

Trips Here and There

THE National Director was privileged to attend the Annual Meeting of the Florida State Nurses' Association which convened in Tampa at the Hotel Mirasol, Davis Island, November 1, 2 and 3. It was her first trip to the "land of flowers and sunshine," consequently it afforded not only a real thrill, but an opportunity to become acquainted with the nurses of Florida and to hear of their problems. Nursing in Florida has made great progress in spite of its many local difficulties and has grown within the past few years from a small group of nurses to an active and alert State Association. From the Red Cross angle, while there are over 400 nurses enrolled in the state, as many of these are of long standing and therefore are not available in time of disaster, a definite effort is being made to increase the number of enrollments from among the younger nurses, to organize emergency units and prepare for quick action in case the disasters of 1926 and 1928 should be repeated. While we hope Florida will be spared a repetition of these destructive hurricanes, nevertheless an "ounce of prevention is worth any number of pounds of cure," consequently the work will go on. The Director came away with delightful impressions not only of the hospitality of the Florida nurses and their seriousness of purpose but of the charm of their state as well.

The latter part of October a visit to Philadelphia for the purpose of speaking at a special service for nurses in the Lutheran Church of the Holy Communion was regarded as a great privilege by the National Director. A procession headed by the vested choir, singing a processional hymn, followed by a group of student nurses in uniform, by Miss Clayton, who introduced the speaker, by the speaker and the clergyman, filed slowly down the side aisle and up the middle aisle, finally occupying their appointed places. The body of the church was well filled with nurses of all denominations, which in addition to the usual congregation made a very large audience. This Lutheran Church has followed this custom for several years, and it is one that might well be emulated by other denominations. A nurse usually addresses the congregation. This time the subject was the Red Cross Nursing Service. An opportunity for the presentation of the more spiritual aspects of nursing, and particularly of the Red Cross Nursing Service was afforded.

Elizabeth Pickett as Motion-Picture Director

MANY Red Cross nurses, especially those who served on the Chautauqua Circuits immediately following the World War, will recall Sarah Elizabeth Pickett who helped to prepare them for this service and at the same time looked after their itineraries. Others will recall Miss Pickett's work on the "Official History of the American Red Cross Nursing Service." For several years she spent the better part of her time assisting with this important task. Still others will recall her as the author of the book, "The American Red Cross, Its Origin, Purpose and Services."

For several years she has been connected with the moving-picture industry as Managing Director for the Fox Film Company. Her first inspiration and experience in this line of

work was obtained while she was with the American Red Cross, for it was she who staged the moving picture: "Following in the Footsteps of Florence Nightingale" and several others dealing with the various phases of Red Cross work. Miss Pickett is now supervising a picture which she wrote, a Story of the Red Men. Reports state that "It is the first all-color and all-sound picture to come out of Hollywood." This Indian movie will bring Richard Dix back into the rôle of the Red Man which he plays so well. Victor Schertzinger, the man who wrote "Marcheta," is also helping with the direction. A recent newspaper report says: "The most patrician woman in the motion pictures wrote it, and the most versatile song composer in the business is behind the megaphone." Miss Pickett is also supervising the making of the picture. Those individuals at Red Cross Headquarters who watched Miss Pickett's development rejoice with her in her success, as will many individual Red Cross nurses who knew her so well at that time.

Disasters

ONE by one the nurses assigned to the great disaster in Porto Rico have returned to the United States. I. Malinde Havey, the Director of the Nursing Service, returned on November 20, leaving Miranda Bradley in charge. Thirty-two American Red Cross nurses were sent from this country, and as many more native nurses were utilized. While the Red Cross work is now largely one of rehabilitation, the health problem is still a serious one, but owing to the good organization which now prevails it was deemed wise to withdraw the American nurses. A large number of typhoid cases concentrated at Aguadilla were in school buildings which were used as temporary hospitals. For these patients the American Red Cross has built a temporary hospital with modern sanitary arrangements, etc. Rose Gonzales, known to a good many American nurses who have had occasion to work with her, was appointed the Supervising Nurse. Miss Havey speaks in the highest terms of the type of work at this institution. Work in first-aid stations, emergency hospitals, inoculations, etc., fell heavily upon the American nurses. One and all, although finding the work very arduous, expressed appreciation for the privilege of being able to share in this important relief work.

The program in Florida at West Palm Beach is rapidly closing. There are still five nurses working under the auspices of Miss Mettinger, the Nursing Field Representative.

From Olean, New York, where Mrs. Charlotte M. Heilman has supervised the nursing care of some 225 patients, which included the establishment of two emergency hospitals and the organization of a large staff of nurses, reports of a decrease in the number of cases and the gradual recovery of those who have been ill, have reached Red Cross Headquarters. There have been twenty deaths, two of nurses, one who contracted typhoid fever and the other who died of a heart condition. Mrs. Heilman speaks in the highest terms of the work of the nurses who have assisted in this unfortunate disaster. While all expenses are being borne by local authorities, the Red Cross Chapter is assisting with certain phases of the relief work, while the nursing activities have been supervised by Mrs. Heilman, the Nursing Field Representative for New York State.

From the Middle West reports of disasters, such as floods, from eastern Kansas, South Dakota, Arkansas and

Missouri, have reached National Headquarters. So far nurses have not been requested. A very large number of families, however, are affected and unquestionably there will be great suffering, due to loss of property and homes. Several lives have been lost. As is usually the case in floods, nurses may be required to assist with the preventive work, such as inoculations.

Enrollments Annulled

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters, and their return is requested when enrollment is annulled: Mrs. Susan Dunn, née Leach; Mrs. Maud Harriet Lawry, née Hayward; Nellie Mary Logue; Mary Marsh Loomis; Margaret Jane McAuley; Mrs. Earl Mace, née Eunice Mathelda Gloger; Mrs. Billy Miller, née Elizabeth Owen; Julia Agnes Murphy; Emma Nicholson; Lucy Isabelle Phillips; Mrs. M. I. Piers, née Julia Eleanor Byron; Florence Grace Pond; Mrs. Annie F. Pope, née White; Inez Marie Potter; Mrs. E. G. Raynor, née Margaret MacDonald; Cora E. Rhoades; Mary Jane Roche; Mrs. Margaret V. Ruth, née Callaghan; Mrs. A. J. Savard, née Margaret Beatrice Blake; Cathryn Schulte; Mary Josephine Small; Mrs. Lela Smith, née Padgett; and Elsie Anne Smith.

An Unfinished Poem

FOLLOWING his death by accident, there was found in the pocket of the venerable Alaskan missionary, Dr. S. Hall Young, these verses:

"Let me die working,
Still tackling plans unfinished, tasks undone,
Clean to its end, swift may my race be run,
No lagging steps, no faltering, no shirking
Let me die working.

Let me die thinking,
Let me fare forth still with open mind,
Fresh secrets to unfold, new truths to find,
My soul undimmed, alert, no question blinking,
Let me die thinking.

Let me die laughing,
No sighing o'er past sins; they are forgiven,
Spilled on this earth are all the joys of Heaven,
The wine of life, the cup of mirth still quaffing,
Let me die laughing."

Student Nurses' Page

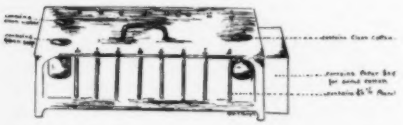
A Modern Hospital Takes Its Temperatures

A. FRANCES FISCHER AND CATHERINE SIMONDS

Pasadena Hospital School of Nursing, Pasadena, California

IT is time to take morning temperatures in the Pasadena Hospital. A nurse comes into the ward carrying the thermometer tray which is not only neat in its appearance but absolutely safe.

While the nurse busies herself with the patients, let us examine the tray. We see that it contains eighteen test tubes with a solution of 1–60 phenol; containers for clean water, green soap and clean cotton. There is also an attachment for a paper bag for soiled cotton which was added to the original tray by the hospital engineer. The tray is made of aluminum.



Our attention is now turned to the movements of the nurse. We note that she has a very definite procedure in taking the temperatures, and the efficiency of the tray depends upon the observation of this routine.

1. Remove thermometer from test tube.
2. Rinse in water.
3. Dry with cotton.
4. Place well under tongue of patient.
5. Remove thermometer, read and record temperature.
6. Dip small piece of cotton in green soap solution.
7. Wipe off thermometer thoroughly.
8. Place soiled cotton in paper bag. Shake down thermometer and return to its test tube.
9. Leave thermometer in phenol for ten full minutes before using again, taking other thermometers in turn.
10. Change the water after every six temperatures.
11. The tray is thoroughly cleaned once a day and the solutions changed. Such care as is necessary is given at other times.

Is this method absolutely safe? Yes, for the following experiment was worked out by two students of the Pasadena Hospital School of Nursing as a check upon former experiments.

Problem—To prove that the above method of taking temperatures is safe.

Procedure:

I. Draw 10 c.c. of blood from cephalic vein of a normal person into a Luer syringe containing 2 cubic centimeters of 2 per cent sodium citrate to prevent clotting. Sterilize 6 Petri plates and divide in half with wax pencil. Melt 100 c.c. of nutrient agar, cool to 37 degrees C. Add the blood obtained and rotate flask until thoroughly mixed. Pour in Petri plates and allow to harden.

II. Experiment:

Plate 1. Take ½ c.c. of the 1/60 phenol with a sterile pipette from "tube 1" before the first thermometer is used.

Plate 2. Take ½ c.c. from the water jar containing sterile water before the

first thermometer is rinsed in it. (Sterile water was used in this case to prove that if any microörganisms were present they would be from the thermometer rather than from the water.)

Plate 3. Take ½ c.c. with sterile pipette from 1/60 phenol solution from "tube 1" eight minutes after the thermometer was used and returned to tube.

Plate 4. With sterile pipette take ½ c.c. from 1/60 phenol from "tube 1" ten minutes after used thermometer is placed in it. (Four checks were run on this step with the same results.)

Plate 5. With sterile pipette take ½ c.c. from sterile water after the sixth thermometer is used.

Plate 6. With sterile pipette take ½ c.c. of 1/60 phenol from "tube 1" just before thermometer is used for last time.

Plate 7. With sterile pipette take ½ c.c. from sterile water into which last thermometer is placed immediately upon removal from patient's mouth.

Incubate plates for 48 hours at 37 degrees C.

Conclusions:

Plates		Plates	
1	(−)	5	(−)
2	(−)	6	(−)
3	(+)	7	(+)
4	(−)		

From the above results we have concluded that the solution of 1/60 phenol acts as a germicide to the forms of microörganisms present on thermometers when and only when the thermometer has been placed in the solution for ten minutes. The above results prove that the method used is absolutely safe and efficient. The results for Plate 7 prove that the agar plates made were suitable culture media for growth.

Upon making Gram stain slides of the colonies found on Plate 7, we found staphylococci, hemolytic streptococci, bacilli and molds.

This is an example of the types of bacteria which are present in patients' mouths, and which are killed by the phenol solution.

Ringworm

IN a recent United States Public Health Bulletin, Surgeon General H. S. Cumming, called attention to the increasing prevalence of ringworm, principally of the feet. This disease, *Epidermaphytosis*, or, ringless ringworm, is relatively new as a widespread disease. Similar conditions, commonly known as ground itch, have been known for a great many years, especially in the South. Recently throughout the United States there have been a great many cases supposedly where the persons have only bathed in carefully supervised pools. After considerable investigation, the conclusion has been arrived at that this infection, which is due to a vegetable parasite—a yeast—probably enters minute abrasions between the toes while persons are walking upon infected floors adjacent to pools or in the sand of beaches.

The disease first is manifested by mild irritation and itching between the toes with slight swelling which soon is covered by a pronounced crust. There may be a small amount of pain.

Because of the persistency of this widespread disease, treatment has received a great deal of attention. Doubtless one of the greatest reasons for this persistency is that one afflicted with ringworm of the feet is liable to reinfect himself. It is an assured fact that this vegetable parasite will stand a great amount of heat and lives for a considerable length of time in fabrics. For this reason, unless stockings are boiled, a person who may be recovering from the condition may reinfect himself by putting on stockings that have been worn while in an infected condition and which, because they have not been boiled for at least fifteen minutes, are still infected.

The following treatments have been found beneficial. Immersion of the feet in a potassium permanganate solution or a solution of bichloride of mercury, 1 to 10,000. A 10 per cent solution of sodium hyposulphite, one cup to two quarts of water, followed 15 to 30 minutes by immersion of the feet in a one-half solution of vinegar also helps. In some cases, mild doses of X-ray have been of service. Whittaker's ointment has also proved of value.—A. M. Johnson, M.D., Health Bureau *Bulletin*, Rochester, N. Y., September, 1928.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

A Warning from Florida

NURSES who are contemplating coming to Florida to work, during the winter, are advised not to come to Orlando, as the present supply far exceeds the demand.

E. JOSEPHINE NOTT,
Secretary District No. 8.

To the Ex-Service Nurses

DESPITE the fact that ex-service nurses are eligible to entry and are daily admitted to U. S. Veterans' Hospitals over the United States, for hospitalization where facilities for the care of women exist, whether the disability is service-connected or not, only a minimum number of them, apparently, know of this privilege. Few, even of the laity, seem to understand this strange phenomenon—a woman patient in an ex-service soldiers' hospital. Many visitors, in fact, on sight-seeing tours through these Veterans' Hospitals express great surprise at the sight of a woman patient, and an explanation is frequently necessary. It seems strange it does not occur to the public at large that nurses all over the United States rallied voluntarily to the call of their country for war service. They, too, gave up good positions and accepted willingly the great hazards of war and gladly gave the best of themselves to their country. It is for such sacrifices that they are entitled to this great privilege of hospitalization with care equal to that of the ex-service soldier, in one of the U. S. Veterans' Hospitals, provided by Uncle Sam, who represents their government and the people of the United States, or in contract hospitals. The number of ex-service nurses applying for hospitalization is increasing as this fact becomes more widely known amongst them. Last year an appropriation was made by the government for the building of a hospital for the care of ex-service women. All information in connection with the procedure of obtaining such hospitalization may be obtained from the nearest Regional Office of the Veterans' Bureau. The law provides that one must have served at some time prior to July, 1921.

A. W. S.

A Rejected Letter

A REPLY to Elsie McCormick's "A Piece of Her Mind," which appeared in the New York *World*, November 12, 1928. (The letter following was written by an ex-patient but his letter was not accepted by the *World*. It was then sent to the *American Journal of Nursing* and is published as a comment by a disinterested outsider.)

To the Editor of the *World*: I dare say there are many hospital patients who on reading Miss McCormick's recent article have felt moved to give "a piece of their mind" also. I myself have no hesitancy in writing to the Editor but I shall beg leave to write of the peace that came to my mind through the kind and tactful ministration of the nurses. Rather recently I was compelled to spend some time as a patient in a hospital and I must say that my experiences were diametrically opposed to those of Miss McCormick so that I find myself interested in making a comparison on several points.

In the first place, let me say that I am a social scientist and as such have a keen interest in the behavior of people. This interest did not desert me during my stay at the hospital; in fact, I seized upon every opportunity to learn something of hospital life from every one with whom I came in contact, especially the nurses. I wanted to know why the nurses lagged so far behind their sisters in the teaching profession; why nurses work twelve hours per day; why nurses serve an arduous apprenticeship without remuneration when most other apprentices are paid during their learning period. Why do nurses not organize for power as other women in modern industry? Are there not any rebels among the nurses? These questions stand in marked contrast to the somewhat personal pique which runs through the McCormick philippic.

It appears that the columnist found her inciting point in an article by Dr. J. J. Golub on "The Tired Nurse." As a lead on which to hang a diatribe, it was quite out of keeping with the fitness of things. I read the article by Dr. Golub in the *Modern Hospital* with great interest and I was particularly pleased to note that Dr. Golub showed serious

interest in the welfare of his coworkers, the nurses.

The chief burden of the McCormick complaint weighs on the score of loquacity and tactlessness of nurses. I did not find the nurses garrulous, but the visitors in an adjoining room carried on as if they were broadcasting in a cabaret. Only after repeated proddings and circuitous questioning did I succeed in extracting responses to my inquiries. Also, I found the nurses' conversation related to the patient's interest. As to the matter of tact, I have only praise. My special nurse, for instance, was a genial little lady with silver-white hair, impeccable uniform and shoes, who would pass as a model in the American Posture League, all of which suggested a quiet dignity. Her well-modulated voice, graceful gestures, smiling mien, and general deportment bore eloquent witness to the possession of intelligence and refinement of character. When my condition no longer warranted the luxury of a special duty nurse, I had an opportunity to observe the so-called general-service nurses. At no time did I find them lax in expected courtesies. The head nurse on the floor was unusually thoughtful in the many little ways which encourage convalescence. Contrary to the imputation that nurses appeal to the patient's instinct of fear, I found the nurses reassuring. In truth the nurses and doctors were so agreeable that in the words of Robert Louis Stevenson, I found the enforced stay at the hospital an unalloyed pleasure.

The suggestion that an operation should be a prerequisite to a nursing career may possibly be a good one; I think, however, that a sensible corollary would consist in requisitioning every patient to take his turn at nursing—a procedure that would likely chasten any hasty criticism of the profession.

It is not unlikely that Miss McCormick's fault-finding might very well have been chargeable to the elements of fatigue—long hours, overwork, unhygienic working conditions, etc., which Dr. Golub attributed to the antiquated physical conditions of the hospital, in which event Miss McCormick should have aimed her missiles, not at the nurses, but at the hospital itself.

New York. M. H.

The Fraternity, Alpha Omega Rho

THE fraternity, Alpha Omega Rho, was organized in accordance with a need that has been long felt among the men in the nursing profession. It had its beginning about a year ago, with thirteen members whose number has now risen to twenty-nine. The primary object of the Fraternity lies in the furtherance of higher ethical standards and in building up the integrity of the profession. Also its purpose is to provide an organization in which problems regarding the vocation may be intelligently discussed. Secondarily, its object is the promotion of social activities. The meetings and business discussions of Alpha Omega Rho are carried out according to the rules that are used internationally. A key is the fraternity emblem.

At present there is no chapter except Alpha Chapter. However, any school of nursing for men which is recognized by the state in which it is located, may inaugurate Beta or Theta Chapters in their order. Alpha Chapter was organized by the students, both Bellevue and affiliating, in the Bellevue school for men nurses and it will continue to conduct its activities there.

Any school desirous of organizing a new chapter may obtain further information by writing to the Hon. President, Alpha Omega Rho, Bellevue Training School for Men, East 26th Street, New York City.

Portraits of Florence Nightingale

THE portrait of Florence Nightingale, illustrated in the November *Journal*, page 1099, are for sale by the Graduate Nurses' Association of the State of Pennsylvania.

PRICE LIST

	Each
A-1, photograph and gold frame.....	$7.00
A-2, 8 x 10 photographs, unmounted, buff, or black and white, head large or small size.....	2.00
A-3, 8 x 10 photographs in folders...	3.50
A-4, 11 x 14 photographs in folders..	8.00
B-1, 11 x 14 enlargements, unmounted.....	10.00
B-2, 14 x 17 enlargements, unmounted.....	15.00
B-3, 16 x 20 enlargements, unmounted.....	20.00

Orders should be sent to the Executive Secretary, Esther Entriken, 400 North Third St., Harrisburg, Pa.

League Reports Wanted

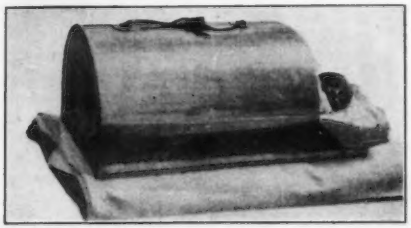
TWO copies, each, of the Reports of the National League of Nursing Education for 1924 and 1925 are desired by the Hospital Library and Service Bureau, 18 E. Division St., Chicago, Ill.

Questions

What is the best type of incubator?

Answer.—A specific answer to a question of this type could be given only after scientific testing of all the types under identical conditions. This, we believe, has never been done. Three well-known maternities answered as follows:

(1) The Cleveland Maternity wrote, "We have used the Hess for over ten years and add a new one every time our finances permit." (The Hess is so well known that we shall not describe it here.)



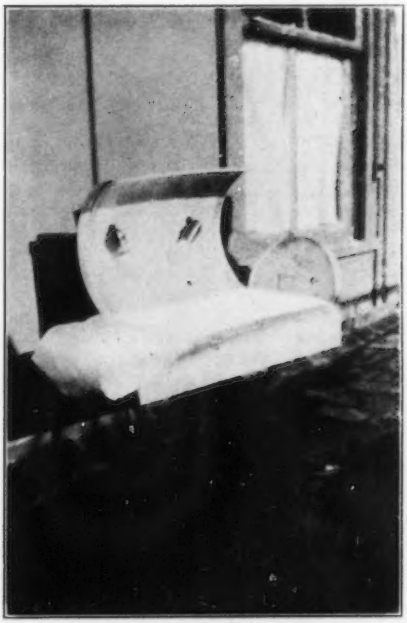
MANHATTAN MATERNITY HOSPITAL INCUBATOR

(2) The Manhattan Maternity replied by sending a reprint of Dr. Walter Lester Carr's paper, "A Clinical Report of Simple Methods in the Care of Premature Babies." From this we quote:

"The incubator room at the Manhattan Maternity is 6½ feet by 7 feet with a ceiling 12 feet high and it has a single door opening from the main nursery. The air intake is from a window by means of a flue, 9 by 2 inches, and the air is carried back of a radiator. The room temperature is kept at 80 degrees.

"The incubator is an aluminum tray, 24 inches in length and 12 inches in width, with a hood 12 inches high that does not extend the whole length of the tray but allows a baby's head to be partially outside of the hood. Over this open end there is a curtain to protect a baby's head and body. The other end of the incubator is closed but has in it a door 4 by 6 inches. In the top of the incubator are 2 openings for electric lights that are placed on elbows so as not to interfere with the clothing. One 15-Watt light will give an incubator a temperature of 96 degrees; two a temperature of 110 degrees.

"The advantage of more than one light in the incubator is appreciated if a baby has many variations of body temperatures as the heat can be raised or lowered according to the requirements, for a moderate heat is found to



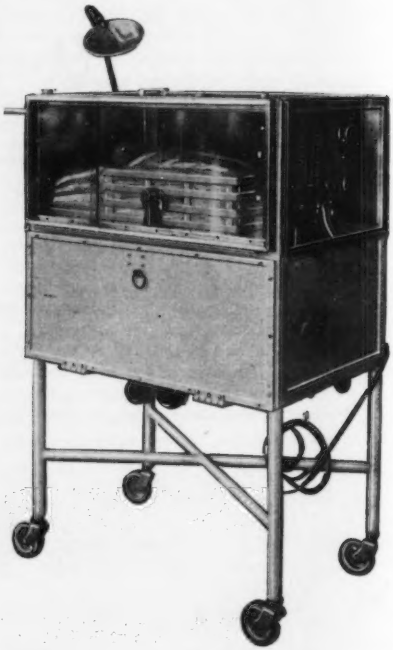
THE INCUBATOR OPEN

be better than a constant high temperature. A thermometer is placed inside the incubator in a position to be observed by the nurse. The temperature of the incubator is maintained at about 90 degrees if a baby's heat is below 95 degrees. As a baby's temperature goes to normal, the heat in the incubator is reduced. The incubator is light in weight and has the advantage of portability and cleanliness."

(3) The Brooklyn Hospital uses the Morgenthaler bed which was designed by Dr.

H. J. W. Morgenthaler of the medical staff.

"The Morgenthaler bed, in use at the Brooklyn Hospital, is a unit in itself, does away with conditioned rooms, isolates the baby from the rest of the nursery, and allows the placing of the bed in any convenient room in the hospital.



"Perhaps the greatest asset of the bed is the maintaining of conditioned air in the bed chambers at a required temperature. Circulation of air is always upwards, through the intake holes at the bottom, around the moistening pad, under the crib, and out over the baby's head. The humidity of the air in the chambers will vary from 50 per cent to 65 per cent, depending upon the temperature of the bed and the humidity of the outside air, and as during cold and dry weather humidity often falls to 30 per cent, maintainance of the above percentage is very desirable.

"Not only can the premature baby be taken care of, but the feeble and sick baby may also be conditioned. The bed is practically fool-proof. The only attention necessary is keeping water in the reservoir and adjusting the thermostat to the temperature required. By following the simple directions, a nurse can maintain the condition desired by the doctor with a minimum of trouble and comes in contact with the baby only at the necessary times."

Is there any danger in cooking food in aluminum utensils?

Answer.—The Bureau of Standards, circular 346, states: "There is no evidence available which would indicate that aluminum cooking utensils represent a potential danger to health. There is no question that if strongly acid or alkaline foods are prepared in such containers, a certain amount of metal will be dissolved and will pass over into the food. It is very doubtful, however, whether a sufficient amount of metal will be found under such circumstances to produce a deleterious effect on the health of persons consuming this food. It should be remembered that certain widely used baking powders contain considerable quantities of aluminum salts and while certain objections have been raised to the use of these aluminum baking powders, the question of their injuriousness has not been definitely established. In the use of aluminum cooking utensils it may, perhaps, be advisable to avoid strongly acid foods. It may also be desirable not to let food stand for many hours in the aluminum cooking utensil."

Abstracts

J. Whitridge Williams, M.D.: Therapeutic Sterilization. (Journal of the American Medical Association, October 27, 1928.)

"I BELIEVE in the justifiability of contraceptive advice under proper conditions, as the more radical procedure of sterilization could be justified only after the former had failed, or in case we are persuaded that our patient is too unintelligent to follow it. . . .

"So far as I can gather, the only relatively reliable contraceptive means at our disposal are the male sheath and the occlusive pessary. The former has been in use for nearly 200 years and was frequently mentioned by Casanova, who died in 1803, while the latter was described by Mensinga fifty years ago, although rudimentary substitutes for it had probably been in use from time immemorial.

"It should be clearly recognized that even these means do not give absolute protection, and all that can be claimed for them is relative efficiency, which will sometimes fail when certainty is most essential. Indeed, it appears to me that the chief benefit which we have derived from birth-control propaganda is the belated recognition, by such writers as Stopes and Cooper, that there is no 'safe time' in regard to the menstrual cycle, and that douches and medicated suppositories merely diminish the chances of conception but cannot be relied on when one is dealing with a medical indication. . . .

"It should be recognized that this has come about in spite of state and national legislation, and that the central government forbids the use of the mails to information concerning contraception, forbids interstate traffic in contraceptive articles, and even prevents their importation for investigative or scientific purposes. The result is that a bootleg traffic has developed, which supplies the demand at excessive prices. . . .

"Where should we stand as medical men? To my mind there can be only one answer, and that is that we must give contraceptive advice whenever it is medically indicated, but that it must depend on our conscience as to what advice should be given under other conditions. I hold that it is just as much our duty to give such advice, when medically indicated, as it is to advocate the employment of any other prophylactic measure.

"We must advise the multiparous woman suffering from chronic nephritis not to become pregnant, and the same applies to tuberculosis and serious heart disease. Consequently, if we feel that such advice is necessary, we must give directions as to how it can be made effective, for if we do one without the other we are failing in our duty as physicians and in great part are wasting our time.

"I likewise feel that similar advice is indicated when we see a patient steadily going down hill as the result of pregnancies recurring at too close intervals, as well as in certain neurotic and maladjusted women whose entire life is disturbed by a constant dread of pregnancy. Indeed, the list of indications might be considerably increased if time and space permitted. In my experience, contraceptive advice will usually accomplish its purpose among the so-called intelligent classes, but it is almost useless among the ignorant, feeble-minded and brutal, and it is in the latter particularly that we must go still further and effect sterility by operative means when necessary.

"For these reasons I give contraceptive advice whenever I feel that it is medically needed, as I consider it far less serious than to induce a therapeutic abortion or a premature labor, which so often becomes necessary when a patient is told not to become pregnant but is not instructed as to how to avoid it. Moreover, when I give such advice, I always regret that the means at our disposal are not more efficient, and that it often must imply a feeling of degradation on the part of the person securing them from semi-bootleg sources. I feel very strongly that our state and national laws should be amended so as to make it possible for physicians to prescribe contraceptive means with the same freedom and decency as any other prophylactic or medical device, and I resent very strongly the attempt of the government to interfere in this respect, as I regard it as an unwarrantable aspersion against the integrity and bona fides of the medical profession."

Jennings C. Litzenberg, M.D.: Obstetrics and Gynecology in Public Health Program.

(Journal of the American Medical Association, November 24, 1928.)

"There is no excuse for the present high death rate in childbirth. If the medical profession could only be induced to apply the knowledge it already has, the maternal mortality would be reduced two-thirds, and ten thousand and more mothers would be saved to their families and to the community.

"The two principal causes of maternal mortality are infection and eclampsia, both almost wholly preventable. In 1925 there were in this country 17,190 puerperal deaths, of which 11,180 were due to sepsis and toxemia.

"By application of the simple requirements of care during pregnancy and asepsis at delivery, thousands of these women need not have died. They died from neglect. It is high time that the medical profession was awakening to the deplorable situation and that the individual physician take on himself the responsibility that is his. By prenatal care, eclampsia can be almost entirely eliminated, to say nothing of the abortions, premature births and stillbirths that may be prevented. Nevertheless, only a small percentage of pregnant women receive such care, because physicians are not insisting on it.

"I know that many, especially country physicians, say the women won't come for it. If they won't, it is the fault of the practitioner —he fails to educate them to the importance of it. I know numbers of rural physicians who are proving that antepartum care can be carried out in country practice just as thoroughly as in city prenatal clinics. They tell me that the farmer's wife appreciates it, and that she will come regularly for her examinations, and that it has been the greatest single factor in building up a good practice."

S. S. Cook and L. L. Williams: Airplanes and Paris Green in Control of Anopheles Production. (Southern Medical Journal, September, 1928, pp. 754–760.)

"The article gives a description of the spread of Paris green by airplanes at Quantico and Chopawamsic Bays, Va. Four charts illustrate the decline throughout the summer of the production of adult Anopheles in the treated localities and compare such production with that of a control, non-treated locality of Aquia Bay. For use in airplane dusting, a dilution of 33 per cent of Paris green in powdered soapstone proved most satisfactory for all conditions. In calm weather an excellent distribution of dust was obtained at a height of 150 to 200 feet above the water. The dust penetrated all types of vegetation indigenous on the Atlantic coast.

"Suitable intervals between dustings varied with the season. At Quantico they ranged from 6 to 13 days. The materials cost approximately 70 cents per acre per season. Practically any type of plane is suitable for distributing Paris green, and a simple box with sloping sides makes a suitable hopper. One plane can handle 20 square miles of breeding surface per week."—From Public Health Reports, issued by U. S. Public Health Service, Nov. 9, 1928.

"Von Meysenbug, L.: Experiences with Banana Feeding in Infants. (Archives of Pediatrics, September, 1928, p. 513.)

"In the routine feeding of the normal baby the banana is of value in supplementing the diet, aiding constipation and often stimulating the appetite. It may be given as early as the fourth month, but must be thoroughly ripe and macerated.

"In scurvy, banana is curative. In celiac disease, the banana is well tolerated and serves to relieve the monotony of the high protein diet. Because of its low protein content, about 0.4 per cent, banana is especially indicated in the diet in nephritis.

"Lastly, because of its palatability, availability and economy, banana is one of our most valuable fruits."

John Early, the Leper, Recovered. (Health News, U. S. Public Health Service.)

John Early, whose case attracted attention for many years, has been discharged from the National Leper Home at Carville, La., after microscopic tests of his blood and tissues have been negative for the leprosy bacillus for more than a year. Health officers of several states and of the District of Columbia have struggled with the problem of providing proper care for John Early for some years. During the early days of his illness, proper facilities were lacking for his housing and care, but since May, 1927, he has been under treatment at the National Leper Home and although he has rebelled repeatedly against the isolation and confinement he now has his reward, although he will be subjected at intervals to examination. There is scant danger of a relapse, however, as since 1921 only one recovered leper discharged from the institution by the Public Health Service has suffered a recurrence of the disease. During the last sixteen months twenty-four patients have been discharged. The treatment with chaulmoogra oil is tedious and sometimes painful.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

The New Year will be welcomed by state treasurers with the annual burst of activity due to the closing of the Association books for another twelve-months' period.

It is a source of gratification to the American Nurses' Association that forty-three state associations now have the calendar year as their fiscal year. This important step toward the unification of the by-laws of state associations and a greater coördination of all national activities in the state groups, has been urged for some time. There has been a tendency toward such unification for some years, and at the Advisory Council meetings in June that body recommended to the Board of Directors that state associations be urged to adopt the calendar year as the fiscal year.

Many complications in membership dues, transfers, and similar organization problems have been occasioned by the varying dates of the closing of the fiscal year, and a considerable amount of additional bookkeeping at Headquarters also has been necessary. So this very helpful uniformity on the part of the states is one of those matters which A. N. A. Headquarters is including in causes for gratitude during the past year.

"The List of Schools of Nursing Accredited by the State Board of Nurse Examiners," in its 1928 revision, has been issued, and orders which have been accumulating during the past months have been filled. Other orders are coming in constantly, a fact which would seem to indicate that the demand for the "Accredited List" is an increasing one from year to year as its value is increasingly recognized.

Seventy-eight new schools appear in the 1928 "Accredited List," and several new features have been incorporated in the present edition. Thus, it is indicated whether the services offered are secured wholly or in part through affiliation. It is shown also whether a course is elective and, if so, whether secured through affiliation. A series of symbols has been used whereby are indicated the schools for colored nurses, for men students, or partly for men students.

The Proceedings (Biennial) are expected momentarily as the *Journal* goes to press, and orders will be filled without further loss of time. In order to facilitate their use, the Proceedings have been digested this year, only the President's address and the reports of the Secretary, the Headquarters Committee, and the Director at Headquarters being given in full.

Addresses given at meetings, round tables, and conferences have been abstracted, only the most important premises and conclusions being given. Reference has been made, however, wherever the address already has appeared, to the magazine in which it was published, and all papers are on file at Headquarters, so that should any nurse wish to read a complete address or to study a subject in its entirety, as presented at the Louisville sessions, she can do so by making her wants known at Headquarters.

Bordeaux School Campaign

Mississippi is the first state to fill its quota in the Bordeaux School campaign. Less than two weeks after the opening of the drive for funds, Mississippi nurses had sent their check for $90.40, the amount of their apportionment. A splendid achievement that, when one thinks of the difficulties and suffering through storm and flood which that state has undergone in recent years. Then came New Mexico. With the campaign just a month old, New Mexico sent the entire amount of its quota of $29.20, being the second state to reach its goal.

When the House of Delegates of the

American Nurses' Association voted in Louisville that $25,000 be raised for the completion of the American Nurses' Memorial building of the Florence Nightingale School of Nursing at Bordeaux, France, many nurses expressed themselves in favor of the assignment of state quotas, not as maximum gifts, but as the minimum amount necessary to be raised by the state associations if the entire amount is to be obtained.

The apportioning of quotas has been done from A. N. A. Headquarters, where the campaign is being conducted. The majority of states have written to say that committees have been organized and will concentrate on the work of raising funds after the Christmas holidays.

A statement follows of quotas and gifts to December 10, 1928:

State	*Quota*	*Gifts*
Arizona	$55.60	
Alabama	192.40	$25.00
Arkansas	160.00	
California	2,112.00	
Colorado	272.00	
Connecticut	744.00	
Delaware	60.00	
District of Columbia	335.60	
Florida	356.80	
Freedmen's Alumnae	24.00	
Georgia	314.00	
Hawaii	29.60	
Idaho	33.60	
Illinois	1,918.80	
Indiana	490.00	
Iowa	652.80	
Kansas	298.00	
Kentucky	223.00	2.00
Louisiana	405.20	
Maine	192.80	
Maryland	631.20	10.00
Massachusetts	1,623.20	
Michigan	1,142.40	
Minnesota	964.00	
Mississippi	90.40	90.40
Missouri	987.60	
Montana	68.40	
Nebraska	319.60	
Nevada	12.00	
New Hampshire	157.60	
New Jersey	811.20	
New Mexico	29.20	29.20
New York	3,906.00	300.00
North Carolina	310.40	
North Dakota	74.00	
Ohio	1,708.40	1.00
Oklahoma	177.20	
Oregon	263.60	
Pennsylvania	2,989.20	25.00
Porto Rico	11.60	
South Carolina	114.80	
South Dakota	57.20	
Tennessee	322.00	
Texas	778.80	
Rhode Island	263.20	
Utah	79.60	
Vermont	102.40	
Virginia	284.00	3.00
Washington	455.20	
West Virginia	162.00	
Wisconsin	$466.40	
Wyoming	16.80	

Nurses' Relief Fund

Report for November, 1928

Receipts

Interest on bank balances	$6.95
Interest on investments	65.00
Benefit check returned	15.00
	$86.95

Contributions

Alabama: District 7, $1.00 per capita	$29.00
California: State Nurses' Association	117.50
Connecticut: Contributed by a former beneficiary	10.00
Georgia: District 1, Georgia Baptist Hospital Alumnae Assn., $59; Wesley Memorial Hospital, Emory University, $10	69.00
Illinois: District 1, Jane McAlister Alumnae Assn., Waukegan, $5; Augustana Hospital Alumnae Assn., $75; Chicago Hospital Alumnae Assn., $10; Englewood Hospital Alumnae Assn., $15; District 11, Lakeview Hospital Alumnae Assn., $5	110.00
Indiana: Indianapolis City Hospital Alumnae Assn., 12 members	12.00
Maryland: Individual contribution	1.00
Massachusetts: Cambridge Hospital Alumnae Assn.	10.00
Michigan: Individual contribution	1.00
Minnesota: District 2, St. Luke's Hospital Alumnae Assn., Duluth, $3; St. Mary's Hospital Alumnae Assn., $4; District 3, St. Mary's Hospital Alumnae Assn., $96; Northwestern Hospital Alumnae Assn., $5; Deaconess Hospital Alumnae Assn., $5; Abbott Hospital Alumnae Assn., $1; District 4, Bethesda Alumnae Assn., St. Paul, $21; Ancker Hospital Alumnae Assn., $6; West Side General Hospital Alumnae Assn., $10	151.00
Missouri: District 3, St. Luke's Alumnae Assn., $60; individual contribution, $3; District 5, $10	73.00
Montana: District 3	15.00
Nebraska: District 1 and 3, $26.50; District 2 (Omaha), Lord Lister Hospital Alumnae Assn., $5; Lutheran Hospital Alumnae Assn., $13; Evangelical Covenant Hospital Alumnae Assn., $20; Clarkson Hospital Alumnae Assn., $35; St. Catherine's Hospital Alumnae Assn., $25; individual contributions, $39	163.50
New Jersey: District 1, Newark City Hospital Alumnae Assn., $600; District 6, $11; collected at State Meeting, $25	636.00
New York: District 2, student nurses of St. Mary's Hospital, Rochester, $10; Genesee Hospital Alumnae Assn., Rochester, $50; University of Rochester Alumnae Assn., $15; individual contribution, $1; District 3, student body Arnot Ogden Memorial Hospital, $50; District 7, $66; District 9, Glens Falls Hospital Alumnae Assn., $10; District 13, St. Luke's Hospital Alumnae Assn., $50; N. Y. Post-Graduate Hospital Alumnae Assn., $100; Staten Island Graduate Hospital Alumnae Assn., $25; City	

Hospital Alumnae Assn., $76; Park Hospital Alumnae Assn., 100%, $18; Presbyterian Hospital Alumnae Assn., $100; Beth Israel Hospital Alumnae Assn., $25; individual contribution, $1; District 14, Mary Immaculate Hospital Alumnae Assn., $10; Nassau Hospital Alumnae Assn., $25; student nurses of Swedish Hospital, Brooklyn, $10	$642.00
North Dakota: Collected at State Meeting, $75; individual contribution, $10	85.00
Tennessee: Riverside-Fort Sanders Alumnae Assn., Knoxville	11.50
Utah: Salt Lake County Hospital Alumnae Assn.	5.00
Virginia: Graduate Nurses' Assn.	300.00
Washington: District 10	30.00
Wisconsin: District 3, $88; District 4 and 5, Mt. Sinai Alumnae Assn., $37; Milwaukee Alumnae Assn., $25	150.00
Total Receipts	$2,708.45

Disbursements

Paid to 197 applicants	$2,757.00
Salaries	227.53
Postage	20.00
Check contributed to Relief Fund returned by bank	23.00
	$3,027.53
Excess of expenditures over income for month of November, 1928	$319.08

NOTE.—In the October report, published in the November *Journal*, an error occurred in listing the contributions received from New York. The amount given as collected at the State meeting represented the cash only; the amounts received from the districts were listed under the district headings. The contribution received at the State meeting should read: District 9, student nurses of Troy Hospital School of Nursing, $75; District 11, Kingston Hospital Alumnae Association, $38; District 13, individual contribution, $5; District 14, Brooklyn Hospital Alumnae Association, $10; cash collected, $184.35. Total, $312.35.

All contributions to the Nurses' Relief Fund should be made payable to the Nurses' Relief Fund and sent to the state chairman. She, in turn, will mail the checks to the American Nurses' Association, 370 Seventh Avenue, New York. If the address of the state chairman is not known, then mail the checks direct to the Headquarters Office of the American Nurses' Association at the address given above. For application blanks for beneficiaries apply to your own alumnae or district association, or to your state chairman. For leaflets and other information address the state chairman or the Director of the American Nurses' Association Headquarters.

The Isabel Hampton Robb Memorial Fund

REPORT TO DECEMBER 11, 1928

Previously acknowledged	$33,695.57

Contributions

Illinois: District 6	5.00
Iowa: Mercy Hospital Alumnae, Council Bluffs	2.50
Minnesota: State Association	25.00
Nebraska: District 1	5.00
New York: State Association	25.00
Ohio: Memorial Hospital Alumnae Assn., Piqua	5.00
Oklahoma: State Association	30.00
Reimbursement on printing bill	15.55
	$33,808.62

MARY M. RIDDLE, *Treasurer.*

The McIsaac Loan Fund

REPORT TO DECEMBER 11, 1928

Balance, November 9	$639.26

Contributions

Illinois: District 6	5.00
Iowa: Mercy Hospital Alumnae, Council Bluffs	2.50
Minnesota: State Association	25.00
Nebraska: District 1	5.00
Ohio: Memorial Hospital Alumnae, Piqua	5.00
Oklahoma: State Association	10.00
Return payment of loan	100.00
	$791.76

Disbursement

Printing	15.55
Balance, December 11	$776.21

MARY M. RIDDLE, *Treasurer.*

Contributions to these funds are welcomed from associations or individuals. Checks should be made out separately and sent to the Treasurer, care *American Journal of Nursing*, 370 Seventh Avenue, New York. Application blanks for scholarships or loans may be obtained from the Secretary, Katharine DeWitt, at the same address.

Transportation, I. C. N.

The American Program Committee for the International Congress of Nurses in Montreal, July 8–13, has appointed Caroline Garnsey, Executive Secretary of the New York State Nurses' Association, 370 Seventh Avenue, New York, N. Y., as National Chairman of the Transportation Committee.

The following regional representatives have been appointed and all local transportation arrangements will be made through them:

North Eastern (Maryland, New Jersey, Delaware, Pennsylvania, New York, District of

Columbia)—Marietta B. Squire, 105 South Grove Street, East Orange, N. J.

South Atlantic (Florida, Georgia, North Carolina, South Carolina, Virginia, West Virginia)—Martha V. Baylor, Roanoke Hospital, Roanoke, Va.

West Coast (Washington, Oregon, Idaho, Nevada, California)—Anna C. Jammé, Room 509, 602 Sutter Street, San Francisco, Calif.

Mountain States (Montana, Wyoming, Utah, Arizona, Colorado, New Mexico).[1]

South Central (Missouri, Kansas, Oklahoma, Texas)—A. Louise Dietrich, 1001 Nevada Street, El Paso, Texas.

North Central (Minnesota, Ohio, Iowa, Nebraska, Illinois, Wisconsin, North Dakota, South Dakota, Indiana, Michigan).[1]

Gulf (Tennessee, Arkansas, Louisiana, Mississippi, Alabama, Kentucky)—Mrs. B. S. Cawthone, Bureau of Public Health Nursing, City Health Department, Memphis, Tenn.

Reduced fares on the *Identification Plan* will be used on all railroads. Round-trip tickets at fare and one-half will be issued to members of the organizations and dependent members of their families. The round trip ticket will be sold at the starting point. Dates of sale will be announced later. Round trip tickets with thirty-day limit will be issued at fare and three-fifths. For some sections the usual summer rates may be less expensive. Consult local ticket agents. All nurses should reach Montreal by evening of July 7.

Guild of St. Barnabas for Nurses

The forty-second annual council meeting of the GUILD OF ST. BARNABAS FOR NURSES will be held in St. Stephen's Church, Wilkes-Barre, Pa., January 30 and 31. On the first day there will be business meetings and a dinner; on the second, a communion service and further business meetings.

Army Nurse Corps

During the month of November, 1928, orders were issued for the transfer of the following named members of the Army Nurse Corps, as indicated: to Fort Leavenworth Kansas, 2nd Lieut. Margaret Sherwood; to William Beaumont General Hospital, El Paso, Texas, 2nd Lieut. Willa M. Phillips; to Fort Sill, Oklahoma, 2nd Lieut. Josephine H. Balestra; to Walter Reed General Hospital, Washington, D. C., 2nd Lieut. Lyda Rodgers; to Hawaiian Department, 2nd Lieuts. Ruby Poss, Florence M. Anderson; to Philippine Department, 2nd Lieut. Edna L. Moat; to San Juan, P. R., 2nd Lieut. Elizabeth Fitch.

Seventeen have been admitted to the Corps as Second Lieutenants.

The following named, previously reported separated from the Corps, have been reassigned: Josephine R. Hall, Grace A. Dermody, Edna C. Dermody, to Fitzsimons General Hospital; Virginia R. Kilroy, to Walter Reed General Hospital.

The following named are under orders for separation from the Corps: Mabel M. Griswold, Natalie D. Rice, Jennie E. Barrett, Helen M. Drew, Anna V. Price, Frances C. Derby, Marie L. Dobson, Theola M. Alexander, Alice C. Johnson, Dorothy M. Morrow, Kathryn Edwards, Katherine Mundell.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

During the month of November, six nurses have been appointed and assigned to duty.

The following transfers were made: to Canacao, P. I., Gertrude M. Burke, Ruth B. Mentzer, A. Frances Womack; to Great Lakes, Ill., Dispensary, Naval Training Station, Katrina E. Hertzer, Chief Nurse; to Great Lakes, Ill., Ada P. Baird, Mary E. Tracy, Hilda G. Nutter; to Guam, M. I., Gertrude K. Zollman, Ruth E. Cleaver; to New York, N. Y., Isabelle M. Leininger; to Norfolk, Va., Lillian L. Reilly, Thomasina Libby; to Pearl Harbor, T. H., Louise A. Bennett, Chief Nurse; to Pensacola, Fla., Sara B. Myer, Chief Nurse; to Puget Sound, Wash., Alice B. Newcomb, Mary W. White; to San Diego, Calif., Nora B. Frederick, Viola G. Abel; to U. S. S. *Mercy*, Isabella F. Erskine, Chief Nurse, Louise D. Von Raben, Iva L. Jones, Helen A. McGrath, Lillian R. Pieper, Agnes M. Byrne.

The following promotions were made: Katherine F. Lowe, Nurse, to Chief Nurse; Emily J. Cunningham, Nurse, to Chief Nurse.

The following nurses were separated from the Service: Gladys L. Van Voorhis, Gertrude L. MacNeil, Edna L. Kuntz, Grace M. Nestle, Karolina M. Sundling.

J. BEATRICE BOWMAN,
Supt., Navy Nurse Corps.

[1] Where a regional representative is not named, Miss Garnsey should be consulted.

U. S. Public Health Service

The following transfers, reinstatements, and new assignments have been made in the U. S. Public Health Service during the month of November, 1928:

Transfers: Mary Nichol, to Stapleton, N. Y.

Reinstatements: Daisy Herbert, to Ellis Island, N. Y.

New assignments: Five.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

U. S. Veterans' Bureau

REPORT OF NURSING SERVICE FOR NOVEMBER

New Assignments: Nineteen.

Reinstatements: Eva Wilcox, Knoxville, Tenn.; Leona Barwiler, Chillicothe, Ohio; Lucie Schwartz, Legion, Texas; Geraldine Kenner, Legion, Texas; Eileen Blackwell, Tucson, Ariz.; Caroline Schwartz, Outwood, Ky.

Transfers: Isabel W. Harris, to Whipple, Ariz.; Margaret Devereaux, to Aspinwall, Pa.; Susanne Hayes, to Sunmount, N. Y.; Gertrude Bastis, to Fort Snelling, Minn.; Rose Kiesel, to Camp Custer, Mich.; Alma Wrigley, to Lake City, Fla.; Frances Bennett, to San Fernando, Calif.

MARY A. HICKEY,
Supt. of Nurses, U. S. V. B.

Report of the Eighth Meeting of the Advisory Committee of Nurses of the U. S. Veterans' Bureau

The Advisory Committee of Nurses of the Medical Council of the U. S. Veterans' Bureau met with the Council at its ninth meeting, in Washington, D. C., November 12–14, 1928. Those present were: Clara D. Noyes, Chairman, Alice E. Stewart, Secretary, Laura Logan, Adda Eldredge, Lucy Minnigerode, Elizabeth G. Fox, Harriet Bailey, Major Julia Stimson, Beatrice Bowman.

The report of the Superintendent of Nurses, Mary A. Hickey, showed that 1924 nurses are on duty in the Veterans' Bureau Nursing Service. There are 52 chief nurses and 398 head nurses. At the present time there are 14,189 patients under the follow-up supervision of the nurses in the regional offices. These patients are distributed as follows: Tuberculosis, 10,686; neuropsychiatric, 1,015; medical and surgical, 2,488. In the hospitals of this Service there are 26,996 patients at this time, distributed as follows: Tuberculosis, 6,741; neuropsychiatric, 13,294; medical and surgical, 6,961.

The need for postgraduate courses was presented. Three diagnostic centers maintained by the U. S. Veterans' Bureau were suggested as possible places in which to hold these courses. The following resolution was unanimously accepted by the Advisory Committee:

"The Advisory Committee of Nurses of the Medical Council of the Veterans' Bureau invites attention to previous recommendations regarding postgraduate instruction for nurses, and desires again to present to the Medical Council the urgency of such training for nurses. Reports received from members of the Advisory Committee of Nursing, who have visited psychopathic, tuberculosis, and general hospitals, disclose that while the nursing in the main is excellent, and the patient well cared for, there are evidences of deficiencies in knowledge in the special branches of nursing, particularly in psychiatric and tuberculosis nursing. In order to assist the Nursing Service of the Bureau, consisting as it does of 1,924 nurses, in a better adaptation to the conditions peculiar to the hospitals and field service of the Veterans' Bureau, a definite program of staff education seems indicated. The Advisory Committee of Nurses, therefore, recommends that an opportunity for postgraduate work be made available, and will be glad to assist in the framing of such a curriculum."

The question of the value of follow-up nursing was discussed after a report from a special committee and its continuance was urged. The resolutions on postgraduate courses of instruction, and follow-up nursing, were submitted to the Medical Council, and referred to the newly-authorized Special Committee on Medical Personnel, of which Dr. Ray Lyman Wilbur is Chairman, and Dr. Roy Adams, Secretary. The purpose of this committee is to deal with all types of postgraduate courses, and the selection of personnel. Laura Logan was appointed a member of this committee by the Chairman of the Medical Council. Miss Noyes was reëlected Chairman of the Advisory Committee, and Miss Stewart, Secretary.

The Indian Bureau

The Nursing Service has had the following changes since the publication of the last report:

Appointments: Ten.

Resignations: Seven.

ELINOR D. GREGG,
Supervisor of Nurses.

Hospital Association Meetings

A joint meeting of the Hospital Association of the State of Illinois and the Wisconsin Hospital Association will be held at the Hotel Sherman, Chicago, February 20 and 21. The Midwest meeting will be held in Kansas City, Mo., February 22 and 23. The Pennsylvania Hospital Association will meet at the Bellevue-Stratford Hotel, Philadelphia, March 12–14. The Indiana Hospital Association will meet April 11 and 12 in Indianapolis.

Protestant Hospital Association

Twenty-five regional committees to be known as consulting committees have been appointed by Dr. J. H. Bauernfeind, President of the American Protestant Hospital Association. It will be the duty of these committees to answer all questions that may be asked by hospital administrators within the borders of their respective districts, and it is hoped that by this method greater efficiency and more economic practices of management will be put into effect in all of the hospitals of the United States and Canada. The chairmen of these committees are: New England, C. W. Williams, New England Deaconess Hospital, Boston; New York City and N. New Jersey, Dr. James E. Holmes, Methodist Hospital, Brooklyn; New York State, I. W. J. McClain, St. Luke's Hospital, Utica; S. New Jersey, E. Pennsylvania, Delaware, Maryland, District of Columbia, Charles S. Pitcher, Presbyterian Hospital, Philadelphia; W. Pennsylvania and W. Virginia, Mary Miller, Presbyterian Hospital, Pittsburgh; Virginia, North Carolina, South Carolina, Georgia, Florida, Alabama, J. B. Franklin, Georgia Baptist Hospital, Atlanta; Louisiana, Mississippi, Arkansas, Dr. Louis J. Bristow, Southern Baptist Hospital, New Orleans; Ohio, Dr. C. S. Woods, St. Luke's Hospital, Cleveland; Kentucky and Tennessee, George D. Sheets, Baptist Memorial Hospital, Memphis; Indiana and Michigan, Dr. George M. Smith, Methodist Hospital, Indianapolis; Chicago, E. S. Gilmore, Wesley Memorial Hospital; Illinois, Clarence H. Baum, Lakeview Hospital, Danville; Wisconsin, Dr. H. L. Fritschel, Milwaukee Hospital; Iowa, Dr. G. T. Notson, Methodist Hospital, Sioux City; Minnesota, Joseph G. Norby, Fairview Hospital, Minneapolis; S. Dakota, N. Dakota, Montana, Dr. A. O. Fonkalsrud, Sioux Valley Hospital, Sioux Falls; Colorado, Nebraska, Utah, Wyoming, Charles A. Wardell, St. Luke's Hospital, Denver; Missouri, Kansas, Oklahoma, Dr. B. A. Wilkes, Baptist Sanitarium, St. Louis; Texas, New Mexico, Arizona, Robert Jolly, Baptist Hospital, Houston; California, Nevada, G. W. Olson, California Lutheran Hospital, Los Angeles; Oregon, Emily Loveridge, Good Samaritan Hospital, Portland; Washington, Idaho, C. J. Cummings, Tacoma General Hospital, Tacoma; Canada, to be appointed; Tuberculosis Group, Guy M. Hanner, National Methodist Sanitarium, Colorado Springs.

American Public Health Association

We are so accustomed to point with pride to our country's public health achievements and to our great prosperity! But we must hang our heads in shame when we point to our maternal health record. With 16,000 deaths a year, the United States leads all civilized countries in maternal mortality rates. Next to tuberculosis, complications of maternity follow as the second highest cause of death for women of the age group 15–45 years. Our great responsibility in saving the lives and preserving the health of child-bearing women was most forcibly brought home in many of the papers given at the fifty-seventh meeting of the American Public Health Association in Chicago, October 15–19. Dr. Livingston Farrand, speaking for President-elect Hoover at the opening session, did not mince terms in pointing this out as the job upon which our efforts must immediately be concentrated. Lines of attack were clearly presented.

The midwife problem had its usual airing with a plea for the elimination of the untrained, unclean, so-called midwife, so prevalent throughout the South. It is estimated that there are 50,000 midwives in the United States, many of whom are licensed without adequate inspection. The need for better training of medical students, especially an improvement in their practical field work, was emphasized. One cannot help but hail the trend toward improved dispensary service that considers prenatal instruction and demonstrations as a required part of the medical student's course. More and better hospitalization for the middle-class mother was urged. More prenatal instruction for mothers, to be given by the doctor and the public health nurse, was stressed, as was the more prevalent use by communities of methods already proven to be effective. The successful rural maternity service in Tioga

County, New York, was graphically pointed out as an example. The work of the Maternity Center in New York City indicated no mortality in 2,000 cases in a metropolitan area cared for in one year. Without doubt this record can be and should be duplicated in many communities with the same kind of intelligent effort and close coöperation.

Atlantic City Meetings

In June, next, 17–21, the following associations will hold meetings at Atlantic City, N. J.: The American Hospital Association, International Hospital Congress, National League of Nursing Education, Children's Hospital Association, American Association of Hospital Social Workers, American Association of Occupational Therapy, American Dietetic Council, American Protestant Hospital Association.

National Council of Women

The National Council of Women is making a particular effort to increase membership in the Special Committee of 1,000 on Social Hygiene, which was started at its Biennial Convention held in New York last December. The suggestion for the formation of this Committee followed a report read by Dr. Katharine Bement Davis, Chairman of the Social Hygiene Committee. This report aroused a desire on the part of the delegates to secure literature and information on the subject of Social Hygiene from reliable sources. Membership in the Committee also entitles the holder to collaborating membership in the American Social Hygiene Association with the privilege of receiving the *Social Hygiene News* and special Social Hygiene literature published by that and other agencies. No membership fee is involved in this collaborating membership. Membership blanks can be obtained by writing the Council office, Room 1534, 370 Seventh Avenue.

Institutes and Special Courses

The first Institute of the Rhode Island League of Nursing Education was opened on Thursday afternoon, November 8, by its President, Grace Breadon, with a short introduction, and the first session was then presided over by Helen O. Potter, Superintendent of Nurses, Rhode Island Hospital, Providence. "Ward Teaching and Supervision" was the topic of a paper presented by Blanche E. Edwards, Director of Supervision, Bellevue Hospital, New York City. Professor Bancroft Beatley, of the Department of Education, Harvard University, demonstrated the points in his discussion of "Motivation as an Aid in Teaching" by the manner in which he held the attention and interest of his audience.

Further practical suggestions for the teacher were presented by Caroline E. Stackpole, Instructor of Biology, Columbia University, New York City, assisted by Angeline Polley, Theoretical Instructor, Homeopathic Hospital, Providence, in a "Demonstration of Material for Science Teaching." Miss Stackpole urged the use of meagre directions, simple problems, and ample time for students' laboratory work that they might learn how to "find out" rather than just amass facts. The evening session, with Mary S. Gardner, Director of the Providence District Nursing Association, presiding, was made notable by the presence of Dr. May Ayres Burgess, Director of the Committee on Grading of Nursing Schools, New York City, and Dean Annie W. Goodrich, of the Yale University School of Nursing. Dr. Burgess gave a talk on the subject of her recent book, "Nurses, Patients and Pocketbooks." Dean Goodrich spoke on the "Growth and Expansion of Nursing Education."

The Institute came to order on Friday, November 9 at 2 p. m., with Ellen M. Selby, Superintendent of Pawtucket Memorial Hospital, presiding and introducing the speakers of the afternoon. The first speaker was Mrs. Francis G. Allinson of Providence, President of the Plantations Club. Her subject was: "The Nurse of the New Century." She said that nurses should firmly believe in their destiny which serves as a basis for working out their problems. The second speaker was Mary S. Gardner. Her topic was "The Public Health Nurse's Job and How to Prepare Her for It." Miss Gardner gave a brief history of the Public Health Movement, dividing it in stages of segregation, sanitation and education. The final speaker was Emma Collins of the Brooklyn Nurses' Official Registry. Her address was "The Coöperative Movement Among Nurses, Which Is Called the Official Registry."

The evening session opened at 8 o'clock with Winifred Fitzpatrick, Associate Director of Providence Visiting Nurses' Association, presiding. The first speaker, Dr. Arthur Ruggles, superintendent of Butler Hospital, Providence, spoke of the different attitude which the public maintains in respect to

persons mentally ill; that Child Guidance Clinics are of recent origin; of the recent creation of the American Foundation for Mental Health.

The final speaker of the Institute was Dr. D. H. Kulp, II, Professor of Sociology, Teachers College, Columbia University, New York City. His question was, "What Does Sociology Say to Nurses?"

In concluding the Institute Miss Fitzpatrick voiced the opinion of all present that it had been an inspiring success and she thanked the many persons who had contributed so generously of time and ability.

Registration numbered 580, including students, graduates in many lines of work, and some from other states.

Commencements

Ohio: Youngstown.—ST. ELIZABETH'S HOSPITAL, a class, on November 22, with an address by Bishop Schrembs.

Texas: Denton.—The DENTON HOSPITAL, a class of two, on November 1, with an address by A. Louise Dietrich.

State Boards of Examiners

Georgia: The STATE BOARD OF EXAMINERS has the following officers: President, Margaret Dorn, Augusta; secretary, Jane Van De Vrede, Atlanta.

State Associations

Connecticut: The GRADUATE NURSES' ASSOCIATION OF CONNECTICUT will hold its annual meeting in Hartford, February 6–8, at the Hotel Bond.

Maryland: The twenty-sixth annual meeting of the MARYLAND STATE NURSES' ASSOCIATION in joint session with the MARYLAND LEAGUE OF NURSING EDUCATION and the MARYLAND STATE ORGANIZATION FOR PUBLIC HEALTH NURSING will be held in Osler Hall, Baltimore, January 29–31.

North Dakota: The sixteenth annual convention of the NORTH DAKOTA STATE NURSES' ASSOCIATION was held in Grand Forks, October 31 to November 2. Evelyn Fox, President, presided. The meeting was well attended and an instructive and enjoyable program was rendered. Dr. James Grassick, of Grand Forks, addressed the joint session of the League and the Association. He chose for his subject "Builders." Justin Granner, Bismarck, gave a report of the A. N. A. meeting at Louisville. Edna Gaither, Bismarck, reported on public health meetings, also held at Louisville. Dr. H. H. Healey, Grand Forks, spoke on the "Nurses' Relation to Modern Times." Sister Lillian Groh, of the United Lutheran Church, told of public health work in China. Dr. H. G. Humpstone, of the University of North Dakota, gave an interesting paper on "Psychology and the Patient." Dr. G. G. Thorgrimson chose for his subject "Immunity"; and Dr. R. D. Campbell, "Business of Being Sick." Dr. H. E. French, Dean of the University Medical School, spoke on "University Affiliation with Training Schools." Mrs. J. A. Poppler, President of the North Dakota League of Women Voters, gave an interesting paper on "Keeping up with the Times."

The annual address of the President of the State Association, J. Evelyn Fox, was on the theme, "Changes That Seem Indicated in the System of Nursing Education in the Light of the Findings of the Grading Committee."

Madora Knox, state organizer of the Business and Professional Women's Club, emphasized the need of organization for women who are employed professionally from the standpoint of improvement in their working condition and from the friendships which are formed. Dora M. Cornelisen, of New York, gave much valuable information in regard to organization, legislation and the Relief Fund. Miss Cornelisen also discussed at length the value of the *American Journal of Nursing*, how it might be used both in and out of the training school. Through her efforts, a committee was appointed to increase the number of subscriptions to the *Journal*. The book, "Nurses, Patients, and Pocketbooks," was also discussed, and each nurse was urged to buy one or more copies. The Association is indeed grateful to the mother organization for sending such a valuable representative as Miss Cornelisen. M. Beatrice Jonstone, University Extension Division, gave an interesting talk on "Hobbies." Bessie Nicoll, State Supervisor of Red Cross Nurses, read a paper prepared by Mrs. Elizabeth Vaughan, of Midwest headquarters of Red Cross.

The Ethel Stanford Miles Memorial Fund was taken up, and motion was carried to expend $100, to endow two beds in the children's ward at San Haven Sanitarium, the remainder to be put in a trust fund for Mrs. Miles' son. The Bordeaux memorial to war nurses was also discussed, and the contribution of $25 to the Near East Relief Fund was voted

upon favorably. Changes in laws covering the registration of nurses and reciprocity with other states were discussed. A committee was appointed to later confer with university authorities in regard to establishing a course of training valuable to graduate nurses in public health work. The Nurses' Relief Fund Committee made a report of $85 collected. The visit to the sugar beet factory by both the League and the Association was interesting and enjoyable. Minot was chosen as the meeting place in 1929. The following officers were elected: Esther Teichmann, Bismarck, President; Mrs. Mildred Isakson, San Haven, and Sister M. Evelyn, Minot, vice presidents; Ella Voge, Bismarck, secretary and treasurer; Mathilda Paul, Minot, corresponding secretary.

The NORTH DAKOTA LEAGUE OF NURSING EDUCATION held its ninth annual convention in Grand Forks, October 31. After the business session, S. M. Sorley, of Eli Lilly and Company, gave an interesting address on "Biologicals." Dr. Grassick, Grand Forks, himself a pioneer and builder, gave a most inspiring talk on the subject of "Builders." Justine Granner, Bismarck Hospital, reported on the biennial convention. Dora M. Cornelisen, Field Representative of the *American Journal of Nursing*, talked on "The *Journal*, Its Builders, Its Purpose, Ways of Using It and State Agents." There was a round-table discussion of nursing-school problems. Mrs. Mildred Isakson, R.N., of San Haven, presided at all meetings.

Texas: Beginning November 15, 1928, TEXAS GRADUATE NURSES' ASSOCIATION is maintaining state headquarters at 1001 E. Nevada Street, El Paso, with A. Louise Dietrich in charge as General Secretary. Miss Dietrich has served the Association as Secretary-treasurer for the past eight years, so this work will not be new to her.

Vermont: The semi-annual conference of the VERMONT STATE NURSES' ASSOCIATION was held in Hotel Berwick, Rutland, October 26. At 1 p. m., the delegation motored to Proctor, to visit the Vermont Marble Works, which was a most interesting and instructive excursion. After the business meeting, a review of Dr. Burgess' book, "Nurses, Patients and Pocketbooks," was given, also two Red Cross life guards gave demonstration of means employed in saving life from drowning. The banquet held in the Dutch dining room of the hotel was a most enjoyable affair. At the evening session, Mildred Whiting, Red Cross Field Representative for Vermont and Western Massachusetts, gave a very pleasing talk on Red Cross work. Dr. B. C. Powers, of Rutland, gave a very instructive talk on "General Physical Therapeutics." It was a most enthusiastic meeting, and very large attendance.

District and Alumnae News

District of Columbia: Washington.—All graduates of the CAPITAL CITY SCHOOL OF NURSING, Washington, D. C., are requested to communicate with the Secretary of the Alumnae, Mary R. Hawkins, Gallinger Municipal Hospital, Washington.

Georgia: First District.—The fall meeting of the FIRST DISTRICT was held in the auditorium of the Atlanta Dental College, October 19, with Cora E. Byers presiding. Annual reports of officers and committees were given; a contribution was voted to the A. N. A. Relief Fund, and to the Grading Committee. Hearty endorsement of the work at State Headquarters was given. (The First District shares the expense of rent on a room at Headquarters for the use of the District in connection with meetings, conferences, etc.) An election of officers resulted as follows: Lillian Alexander, Atlanta, President; Jessie Veazey and Mrs. J. F. Hawthorn, vice presidents; Mrs. Sue Paille, secretary; Blanche Fearnside, treasurer; Mrs. E. H. Fell and Lillie Miller, directors. On this date the total paid membership of the District was 496. GRADY HOSPITAL ALUMNAE ASSOCIATION recently celebrated its twentieth year of activity, having been organized in 1908. The Association has a paid-up membership of 66. At present it is making a study of "Nurses, Patients and Pocketbooks." The Association finances a room in Grady Hospital for sick nurses. This is used also by student nurses, and has even been tendered to an "outside" graduate, who was attended by Grady graduates, without charge. Annually the organization sends a delegate to the State Association and, beginning this year, it will send a student nurse to the convention. This Alumnae Association has a loan fund for members, maintained yearly by a Thanksgiving offering. At present this fund amounts to almost $400. Other contributions made by the Association are to the Memorial of the Bordeaux School, the Grading Committee work, A. N. A. Relief Fund, and to the support of Headquarters of the State Association. ST. MARY'S HOSPITAL ALUMNAE ASSOCIATION is more active than at any time in the past. Elizabeth Hale was recently reëlected president, and Jessie Mae Branyon, secretary-treasurer. A room in St. Mary's Hospital, in

KATHERINE A. SANBORN, R.N.

memory of Dr. J. P. Proctor, has been furnished and dedicated, and is being maintained by the Alumnae. The Senior nurses in training are associate members, which stimulates interest in the organization. **Third District.**—New officers in the THIRD DISTRICT are: Martha Cheevie Moore, president; Myrtle Lomax and Mrs. Mae M. Jones, vice presidents; Winnie Wood, secretary; Bessie White, treasurer; Bessie Taylor and Myrtle Thompson, directors. **Fourth District.**—The regular meeting was held at Oglethorpe Sanatorium, Savannah, November 30, Martha Gatzka presiding. State convention reports were given, and Mrs. E. S. Westcott read Mrs. Anne L. Hansen's paper, "The Nurse and the Community." Each Alumnae Association pledged itself to dispose of ten of the League calendars for 1929. A Committee on Revision of By-laws was empowered to act in conjunction with a similar committee in the State Association in making the District by-laws conform to standard. Mrs. Rhodes, Chairman of the Private Duty Section, reported that meetings of this group would be held regularly the last Monday, every other month. ST. JOSEPH'S ALUMNAE ASSOCIATION.—The following officers were elected to serve for 1929 at the November meeting: Agnes Dugan, president; Gertrude Dulohery, vice president, and Helen F. McNally, secretary and treasurer.

Indiana: Huntington.—The annual meeting of the FIRST DISTRICT was held November 10, at the Hotel La Fontaine, with a luncheon. Sixty-two members were present for luncheon; others came in for the program and business meeting. Mrs. G. Van Sweringen, Chairman, presided. The invocation was given by Rev. Joseph W. Gubbins. Music was furnished by graduate nurses of Huntington County Hospital. Arthur H. Sapp of Huntington gave a most interesting talk on "Happiness." The next regular meeting will be on January 12, at St. Joseph's Hospital Nurses' Home, Fort Wayne.

Iowa: Dubuque.—The regular meeting of DISTRICT 3 was held November 12 at the home of Miss Pedersen, with forty-one members present. An excellent report of the State convention held in Council Bluffs was given by Miss Pedersen. Ada Hartman, the student delegate sent by the Finley Hospital Alumnae, gave a very enthusiastic report of the convention, from the student nurses' viewpoint. Ways and means were discussed for raising our quota toward the completion of the Nightingale School in France. **Iowa City.**—The UNIVERSITY ALUMNAE held a bazaar, the proceeds to be used in furnishing a room at the hospital for the use of alumnae members. DISTRICT 5 held a meeting at Westlawn on November 30. Dr. Plass gave an interesting talk. Reports of the State convention will be given at the next meeting to be held in Cedar Rapids, at St. Luke's Hospital.

Michigan: Detroit.—The GUILD OF ST. BARNABAS FOR NURSES asked a Committee of Student Nurses to suggest topics for addresses for the weekly meetings to be held at each of four hospitals, Ford, Grace, Harper and Woman's. A total list of fifty-one topics has been compiled and given to the chaplains as a guide in preparing for the meetings. The topics indicate a very real interest in medical missions. Many of them show how seriously these students are endeavoring to reconcile the teachings of science and the teachings of religion. The plan seems wholly constructive and one which should definitely help to enrich the spiritual lives of nurses.

New York: New York.—The ALUMNAE ASSOCIATION OF ST. VINCENT'S HOSPITAL held a reception on the evening of November 22, in honor of Katherine A. Sanborn, on the twenty-sixth anniversary of her work as

Director of the School of Nursing. Sister Felicita, Superintendent of the Hospital, spoke very feelingly of the work which has been done by Miss Sanborn through these years. Helen J. Gorman, President, and several other members of the Alumnae Association, spoke of Miss Sanborn's influence on them in their chosen work. Miss Sanborn's work has been characterized not only by her ability as a nurse and teacher, but by her deep personal interest in every student who has passed through her school. An autographed book and a purse were presented to Miss Sanborn, with felicitations from all those present. Two of the three nurses who were probationers when Miss Sanborn went to the hospital attended the reception. The hospital and staff had honored Miss Sanborn at an earlier date. Miss Sanborn treasures a memory-book which contains greetings from her widely scattered nurses and a title page written by Dr. David Stewart. **Rochester.**—Lillian A. Douglas has resigned her position as Superintendent of Nurses at Highland Hospital. Miss Douglas will be greatly missed. She was chairman of the Local Red Cross Nursing Service Committee, and she took an active part in all nursing activities of the city.

North Carolina: Kinston.—WILSON DISTRICT 8 NURSES' ASSOCIATION held a meeting here in November, at the Gordon Street Christian Church, with an attendance of twenty-eight. The interesting program included papers on "Focal Infection," by Dr. A. L. Wooten; "Child Welfare," by Clara Brady; and a report of the State meeting by Mrs. Mamie Little.

Ohio: Dayton.—The regular meeting of DISTRICT 10 was held, November 28, at the Nurses' Home, Miami Valley Hospital. Anna Davis, Assistant Superintendent of the Navy Nurse Corps, gave a very interesting talk on "Navy Nursing." She brought with her a number of slides to illustrate her talk. The members were very glad to have Miss Davis with them, and hope other districts will be able to hear her.

Oregon: Portland.—At the meeting of the NORTHWEST HOSPITAL ASSOCIATION held in Seattle, November 30, Emily Loveridge read a paper, "Care of a Patient's Valuables and Effects." Margaret Frances Kelling has been appointed Superintendent of Nurses at Multnomah County Hospital, succeeding Kathleen Davern.

Pennsylvania: Pittsburgh.—The MARY BUDD TURPIN MEMORIAL LECTURE was given in Carnegie Music Hall, December 7. The

EUNICE F. WHIPPLE, R.N.
Newly-elected Director of Official Registry Service, New York City

speaker was May Ayres Burgess, on "Nurses, Patients and Pocketbooks." **Scranton.**—The regular meeting of the DISTRICT ASSOCIATION No. 3 was held at the Nurses' Home of the Nanticoke State Hospital, November 22. The regular business was transacted and reports of the State convention, held in Altoona, were read.

Texas: Galveston.—The following officers were elected by DISTRICT 6 for 1929: President, Bertha Boeker; secretary-treasurer, Zora McAnelly—both of Galveston. **Wichita Falls.**—DISTRICT 11 closed a very successful year with a meeting at the General Hospital, November 15. The following officers were elected for 1929: President, Dorothy Loope; vice presidents, Mrs. O. B. Ambrose, Mrs. Carrie Swanson; secretary-treasurer, Mildred Baker; corresponding secretary, Vera Bamberg; directors, Eva M. Wallace, Mrs. Fannie W. Rice. Reports of the accomplishments of the past year were reviewed and plans were laid for a busy and profitable new year.

Wisconsin: Ladysmith.—Saturday November 24, marked the organizing of the ALUMNAE OF ST. MARY'S SCHOOL OF NURSING. Several officers and members of the Tenth District were present, among whom were Clara Lewis, and two Franciscan Sisters from

the Sacred Heart Hospital, Eau Claire.

Milwaukee.—The MILWAUKEE LEAGUE OF NURSING EDUCATION is conducting a campaign for increased membership. It is also sponsoring group meetings for the discussion of common problems. Group meetings have been held for superintendents, instructors, obstetrical supervisors, floor supervisors, and operating-room supervisors. A study is also being made of the book, "Nurses, Patients and Pocketbooks."

Deaths

Iracema Dos Santos Cabral (class of 1926, Anna Nery School of Nursing, Rio de Janeiro, Brazil), at sea, November 11, 1928. Miss Cabral, who was only 24, came to this country a year ago to study public health nursing. She left the port of New York on the S. S. *Vestris*, on November 10, to return to Brazil, where her work as public health nursing supervisor in the National Department of Health was awaiting her. The friends who went to the ship to see her off said that she was very happy in the thought of seeing her family again, and very eager to begin her new work. We shall never know exactly how her life came to an end, but it seems most probable that she was in the first life boat to be lowered, which was wrecked as soon as it reached the water. Most of the children were in this boat, and Iracema Cabral's friends say that they are sure she would have gone with the children to help take care of them. Iracema Cabral had a true and fine perception of what it is to be a nurse. She made this impression wherever she went. Letters from Philadelphia and from Toronto, where she had been studying, are filled with expressions showing how she had endeared herself to her new friends in the United States. The loss to the work which she was to do in Brazil will be great.

Julia Johnson DeWitt (class of 1910, Swedish Mission Hospital, Omaha, Nebr.), on October 19, 1928, after an illness of but a few hours. Mrs. DeWitt was of a happy disposition; she scattered sunshine wherever she went, and was always ready to serve others.

Ada P. Janney (Columbia Hospital, Washington, D. C.), at a private sanitarium, Catonsville, Md., November 29, 1928, after an illness of several months. Miss Janney was at one time Superintendent of Loudoun County Hospital, Leesburg, Va., and later, of Bay View Hospital, Baltimore. She was Secretary of the Y. W. C. A. in Baltimore for some time. Burial was at Lincoln, Va.

Mary Margaret Lavin (class of 1911, South Carolina State Hospital), on November 5, 1928, at Columbia, S. C. Miss Lavin held various institutional positions until 1914, when she accepted a position with the late Dr. J. W. Babcock in his private sanitarium, Waverly, where she remained until three weeks before her death. She was a patient sufferer, a faithful nurse, loyal to her profession and friends, beloved by them and by her patients.

Hannah Olson (class of 1901, Moorhead Hospital, Moorhead, Minn.), on November 22, at Minot, N. D., following a short illness of heart disease. Miss Olson took postgraduate work at the Polyclinic Hospital, Chicago. She had been faithful to her profession, having practiced for more than twenty-five years. Her work was chiefly in and out of Minot. Miss Olson was a charter member of the North Dakota State Nurses' Association; she was a member in good standing at the time of her death. Burial was at Homestead, Mont.

Mary Gertrude Spencer (class of 1908, Rhode Island Hospital, Providence, R. I.), recently, at her home in Providence, after a long illness. Miss Spencer held various positions of trust and responsibility during her nursing life; she was at the Crawford Allen Hospital, East Greenwich; held several positions at the Rhode Island Hospital, including that of orthopedic nurse for Dr. Danforth; she was a member of her own Alumnae and State Associations, and a member of St. Barnabas Guild for Nurses.

Mrs. Katharine Harris Stines (class of 1900, Ancker Hospital, St. Paul, Minn.), on November 29, 1928, of influenza-pneumonia, at Covina, Calif. Mrs. Harris had been nursing two relatives with the disease; she contracted it herself, and lived but a few days. She was a loyal member of District 5, Los Angeles, where her friends were legion.

La Belle Walker (class of 1926, State University of Iowa Hospital, Iowa City, Iowa), recently, at Ray, Ariz., following an operation. Miss Walker was in charge of a hospital in Arizona. Burial was at Iowa City.

Melrose Williams (class of 1927, Arkansas City Hospital, Arkansas City, Kansas), on October 22, 1928, at Norton, Kans., after an illness of one year.

Too Late for Classification

(Because of the holidays, the *Journal* pages went to press before all the items had been received. Most of these would have been in time for the usual closing date.)

Arizona: The STATE BOARD OF EXAMINERS will hold a meeting in Phoenix, January 12.

MISSISSIPPI STATE BOARD OF HEALTH, PUBLIC HEALTH NURSES AND EXECUTIVE OFFICERS

Indiana: Indianapolis.—THE INDIANAPOLIS CITY HOSPITAL NURSES' ALUMNAE ASSOCIATION held its annual meeting at the hospital, November 24. Officers elected were: President, Mrs. Mabel S. Huggins; vice presidents, Mrs. Grace Stevens, Mrs. Beryl Miller; secretary, Mary Mullen; treasurer, Mrs. Vera Kenagy. The Constitution and By-laws were amended to conform to the plan of the American Nurses' Association. It was voted to contribute 40 cents per capita towards the completion of the Florence Nightingale School of Nursing at Bordeaux, France; also, it was voted to contribute $50 per year to the Grading Committee as long as it continues to function.

Michigan: Dr. May Ayres Burgess, Director of the Grading Committee, and Dr. Reinhold Neibuhr, of Union Theological Seminary, New York, will be speakers on the program of the meeting of the MID-WEST DIVISION of the American Nurses' Association which will be held in Detroit, April 12 and 13. The annual meeting of the MICHIGAN STATE NURSES' ASSOCIATION will be held in conjunction with this meeting. **Detroit.**—Dr. Daniel A. Kulp, Assistant Professor of Education at Columbia University, was the speaker at the December meeting of the DETROIT DISTRICT, held in the Educational Building of the Henry Ford School of Nursing and Hygiene. The monthly meeting of the HENRY FORD HOSPITAL ALUMNAE ASSOCIATION was held at the Clara Ford Nurses' Home on December 3. William Lovett, editor of the *Civic Searchlight*, gave a talk on "Is Democracy a Failure?" **Kalamazoo.**—Mary C. Wheeler, General Secretary of the State Association, was the speaker at a special meeting of the ALUMNAE ASSOCIATION OF BORGESS HOSPITAL, in November. **Port Huron.**—The graduating exercises of the PORT HURON HOSPITAL SCHOOL OF NURSING were held on December 5. Frances Millyard has gone to Bangkok, Siam, to become assistant superintendent of the Rockefeller Foundation Hospital. **Saginaw.**—At the annual meeting of the ST. MARY'S HOSPITAL ALUMNAE ASSOCIATION, Mary McGovern was elected president; Anne Davis, vice president; Bridget Fleming, secretary; and Anne Allen, treasurer.

Mississippi: The MISSISSIPPI STATE NURSES' ASSOCIATION held its seventeenth annual meeting in Jackson, October 25–26. The Thursday morning session was devoted to business and reports, followed by a round table for Superintendents of Nurses, Mrs. Varnado presiding. In the afternoon, Mary D. Osborne gave a report of the Louisville Convention and Emma Taylor discussed the

report of the Grading Committee. Reports of county and alumnae associations were given. A Hospital Section was held at which Sara King presided. A paper on "Hospital Management" was given by Mrs. F. Collins. After the meeting the members had an auto ride, and visited the new State Hospital. In the evening an open meeting was held at which Hon. H. M. Bryan presided. The invocation was given by Rev. T. W. Brownlee and the address of welcome by Mayor Scott. The response was made by Selma Rhodes. The President's address by Rose Keating was followed by addresses by Dr. J. W. Barksdale and Hon. P. H. Eager. On Friday morning the meeting was held at the Central High School under the auspices of the Public Health Section, Inez Breland presiding. Hygiene class exercises were given and then papers by Mrs. Jessie A. Adams on "Work of the State Commission for the Blind," and by Dr. Henry Boswell on "The Public Health Nurse and the Campaign against Tuberculosis." On Friday afternoon, Janet M. Geister of the American Nurses' Association spoke. At the Private Duty Session, following, Bessie Brougher told "Why I Am Glad I Am a Nurse," and a paper was given by Mrs. Lea A. Evans. Anne Roller spoke on the *American Journal of Nursing*.

Missouri: The MISSOURI STATE BOARD OF NURSE EXAMINERS will hold its next examination in St. Louis and Kansas City, February 6 and 7. Janett G. Flanagan, Secretary.

Nebraska: The twenty-third annual meeting of the NEBRASKA STATE NURSES' ASSOCIATION met at the First Methodist Church, Omaha, on October 18, and was called to order by the President, Florence McCabe. The morning session was chiefly business, and reports from the various districts and committees were given. We may especially speak of our Membership Committee, who have done splendid work in increasing the memberships. Two papers were given: "High Lights of the American Nurses' Association Convention," by Sr. Olive Cullenberg, and "Résumé of the Evaluation of the Schools of Nursing," by Phoebe Kandel, Director of Nursing Education in Nebraska. Thursday afternoon, Walter Pierpoint, of the Chamber of Commerce, delivered an address of welcome; Florence McCabe responded. There were several addresses, including "Legislation" and "Savings and Investments," something of which every nurse should know and begin as soon as possible. A lecture was given on "Mental Diseases" by Dr. Benjamin Williams of Lincoln, followed by an address by Mary M. Roberts, on "The Present Nursing Situation in Our Country," after which all were guests of the Omaha hospitals alumnae associations at a tea at the new Knights of Columbus Club. The evening session consisted of an organ recital and an address on "The Spirit of Nursing," by Rev. Dr. Frank Smith. We also had the great pleasure of hearing Dr. Edward Steiner's address on "Adult Education." The NEBRASKA STATE LEAGUE OF NURSING EDUCATION met October 19. Lulu Abbott presided. A report of the National League of Nursing Education was given by Carrie Eppley. An address and a demonstration of a hot body pack were given by Myra Tucker and students of the University Hospital. Phoebe Kandel then gave a paper on "Records." Mary M. Roberts was leader of the Round Table of Private Duty Section and Edna Foley leader at the Public Health Section. A general session followed, where an address on "The Physical and Mental Health Factors Essential to Production of Good Nurses" was given by Marion J. Faber. The afternoon session opened with an address on "Vocational Education Aspects of Navy Nursing Service" (with lantern slides), by Anna G. Davis of the Navy Nurse Corps. An address by Edna Foley and a report on the "Grading Committee" by Mary M. Roberts followed. A dinner at Hotel Fontenelle in the evening was well attended and an address, "University of Hard Knocks," was delivered by Ralph Parlette. On Saturday morning, unfinished business was attended to and report of tellers. The following officers were declared elected: President, Florence McCabe, Omaha; vice presidents, Myrtle Dean, Lincoln, and Orta Lewis, Hastings; secretary, Ingrid Beck, Omaha; treasurer, Veta Pickard, Omaha. Two instructive addresses were given: "The Spirit of Red Cross," by Mrs. Ainsworth; "What Can the Nurse Do in the Control of Cancer?" by Dr. Palmer Fridly. The afternoon session opened by an address, "What Does the Registry Offer the Private Duty Nurse?" by Mary Muckley of Minnesota, after which a discussion took place. A lecture on "A Unified Program of Community Welfare," by Howard E. Jensen of University of Missouri, was delivered.

New Jersey: Newark.—The NEW JERSEY LEAGUE OF NURSING EDUCATION will conduct its annual institute on nursing education at the nurses' residence of the Newark City Hospital, Newark, on Thursday and Friday, January 24 and 25. The program for the institute is being arranged by the Instructors' Section of the League; chairman, Grace

Watson, Educational Director of the School of Nursing of the Jersey City Hospital.

Ohio: Canton.—DISTRICT 1 held a meeting of the Educational and Public Health sections on December 10. The program was given by students of the Aultman and Mercy hospitals. **Cincinnati.**—DISTRICT 8 decided to dispense with the regular monthly meeting in December because of the many activities of the holiday season. During November, the ALUMNAE ASSOCIATION OF THE JEWISH HOSPITAL gave a bazaar for the benefit of the Alumnae Scholarship Fund. The ALUMNAE ASSOCIATION OF THE SCHOOL OF NURSING AND HEALTH gave a bazaar for the benefit of their Alumnae Sick Fund. On December 6, the CHRIST HOSPITAL ALUMNAE ASSOCIATION held a bazaar, the proceeds to be used for the endowment of a room in the new hospital for the Alumnae members. The PUBLIC HEALTH SECTION OF DISTRICT 8 held its regular monthly meeting, December 12, at the Emanuel Community House. Dr. Wilzbach of the Public Health Federation gave a very interesting address. **Cleveland.**—DISTRICT 4 held a meeting on November 20, when Janet M. Geister spoke on "What Can I Do About the Nursing Problem?"

Rhode Island: The annual meeting of the RHODE ISLAND STATE NURSES' ASSOCIATION will be held January 30, at the Medical Library, Providence. After the business session, Colonel H. Anthony Dyer will speak on "Travels in France and Italy."

Vermont: Newport.—The ORLEANS COUNTY COMMUNITY HOSPITAL graduated a class of six, on December 7, with addresses by Judge F. C. Williams and Jean F. Beaton, the Superintendent.

American Social Hygiene Association: The annual meeting of the AMERICAN SOCIAL HYGIENE ASSOCIATION will be held in New York, January 18 and 19. The business meetings will be held at the Hotel Pennsylvania. At the luncheon there, January 19, the speakers will be Col. L. W. Harrison of the Ministry of Health, Great Britain, Jane Addams, and Mrs. Anna Garlin Spencer.

Colorado: The annual meeting of the COLORADO STATE ASSOCIATION will be held in Denver, February 5–7. It is hoped that Dora M. Cornelisen, Field Representative of the *American Journal of Nursing*, will be a guest and speaker.

Maine: The annual meeting of the MAINE STATE NURSES' ASSOCIATION will be held at the Eastland Hotel, Portland, January 4–5.

Death: Agnes Stook (class of 1912, Broad Street Hospital, Oneida), on November 10, in Rome, N. Y. Miss Stook was Assistant Superintendent of the Broad Street Hospital for a number of years; she was also a visiting nurse for some time, and a private duty nurse. She was a charter member of her Alumnae Association. All who knew her loved her and respected her. She was always kind, thoughtful and cheerful.

"Journals" Wanted

COPIES of the *Journal* for January, 1911, and for December, 1918, are wanted by Mrs. W. P. Bossenberger, 2431 Smalley Court, Chicago, Ill. She will pay $1 apiece for them. (Write before sending them.)

The Boston Nurses' Club, 839 Boylston St., Boston, wishes to purchase copies of the *Journal* for October, November, December, 1909, and January, 1910.

The Need for Rural Health Work

IN our rural communities there are about 1,000,000 persons incapacitated all the time by illness, much of which is preventable; about 70 per cent of the school children are handicapped by physical defects, most of which are preventable or remediable; about 30 per cent of persons of military age are incapacitated for arduous productive labor or for general military duty, largely from preventable causes; and over 60 per cent of the men and women between 40 and 60 years of age are in serious need of physical reparation, largely as a result of preventable causes. In view of these conditions, there is no room for reasonable doubt about the need for more and better rural health service in this country.—U. S. Public Health Service, December, 1928.

Nurses' Training School at Antioquia

THE Colombian Red Cross (Antioquia branch) has a training school for nurses where a three-years' course of training is held. The demand for nurses at the present time so far exceeds the supply that the Red Cross may be compelled to reduce the period of training, temporarily, from three to two years.

The theoretical classes are held in the University, practical work being taken at the Hospital of St. Vincent de Paul. In future

the Medellin Hospital, put at the disposal of the Red Cross by the Public Health and Welfare Board, will also be available for the training of nurses.

The classes for 1928 are being taken by nineteen students who are studying for the Red Cross diploma.—From the Bulletin of the League of Red Cross Societies, October, 1928.

Importance of Undulant Fever Being More Widely Recognized

UNDULANT fever, a disease contracted from cattle and hogs which are infected with contagious abortion, is being more widely recognized as a problem of considerable importance from a public health standpoint. A number of cases have been reported from various states. The disease is quite prevalent among cattle and hogs throughout the country. Persons who drink raw milk from infected cattle or who handle hogs or cattle that are infected are likely to contract it. The name, "undulant fever," is applied because the attacks of fever come in waves or undulations. The disease was first recognized on the island of Malta in the Mediterranean, and it was thought for a time that it was spread only through the milk of goats. It is now known, however, that it may be contracted from cattle and hogs. The disease is not only disabling but chronic in duration. The patient may be ill for two or three years before any improvement is noted. Important studies made by Alice C. Evans, a bacteriologist of the United States Public Health Service, have shown the relation between this condition in human beings and contagious abortion in cattle. In certain states it has been said that undulant fever is of greater importance from the standpoint of public health than is typhoid fever. Many cases are contracted from infected milk. Fortunately, however, efficient pasteurization readily destroys any of the germs which may be present in milk. The chief precautions, therefore, are the use of pasteurized milk and care when coming in contact with animals known or suspected to be infected with contagious abortion. In a series of cases of undulant fever recently studied among adults living on a farm, there were thirty-nine males and six females; six of the male cases are known to have derived their infection from hogs.—U. S. Public Health Service, December, 1928.

Treatment of Burns

AS a subscriber to the *American Journal of Nursing*, employed at a Bureau of Nursing Service, I thought it would be of interest to the *Journal* office to know that the article on the "Treatment of Burns," in the September issue, has attracted the attention of several of the local physicians. Doctors have personally visited our office and expressed their interest in the article, and asked permission to take the *Journal* out. The foregoing we feel adds professional prestige to our profession, as well as to our pride in our national publication.

California. E. J.

About Books

Ask your local public library to lend you these books if you cannot own any or all of them

OBSTETRICAL NURSING. By Carolyn Conant Van Blarcom, R.N. Second edition, revised. 575 pages. Illustrated. The Macmillan Company, New York. 1928. Price, $3.

THE new second edition of Van Blarcom's "Obstetrical Nursing" is now ready to replace the first. When Miss Van Blarcom published her first book, it was hailed with joy by instructors and supervisors of obstetrics. It was thought to be the most complete and comprehensive volume that had yet been published on maternity care; it was written by a nurse instead of by an obstetrician and emphasized the duties and privileges and opportunities of the nurse who chooses to serve in this most important field of nursing.

The second edition follows the general plan of the first, taking the student through a review of the anatomy of the female pelvis and generative organs, giving the physiology of reproduction, the development of the embryo, and the growth and habits of the fetus.

Prenatal care is introduced at this point, thus stressing the importance of hygiene on the part of the mother and the part she plays in the future health of the child and in the health of that same child, later, as a prospective member of the community.

The chapter on "Mental Hygiene of the Expectant Mother" is enlightening to the student who has not realized the reasons for depressions, moods, irritability, or nervousness displayed so often by the pregnant woman. This chapter is summed up in the following paragraph:

> The expectant mother who habitually has not made satisfactory adjustments during her life may be bending under a mental burden that is a little heavier than her slender, unevolved powers can bear. The nurse's part is to recognize this possibility and realize that, while she cannot attempt to correct the difficulty, she can be a prop by simply being optimistic and reassuring. A patient who may be suffering from a mental conflict is often saved from a breakdown by little more than a ready sympathy which is born of understanding.

Those parts devoted to the preparation and care in the home are of particular interest and charm. Even an instructor who has not had experience in a maternity out-patient department or as a visiting nurse would be able, through the text and illustrations, to give her students a real picture of the obstetrical nurse in the home, using tact and ingenuity to give the best kind of care with the least amount of expense and worry to her patient or the family.

The nurse's duties during labor are outlined in detail and of particular value in this chapter are the pages describing anesthetics used. These are classified under three headings—anesthetics, analgesics and amnesics.

The Gwathmey method of rectal anesthesia has a prominent place and deserves special mention, the author giving a full description of the formula and procedure with details of technic and necessary equipment. The illustrations complete the picture, leaving

no questions in the mind, so clear and simple is the lesson.

Perhaps the most interesting part of the book is the section containing two chapters on "Provisions for Maternity Care in the United States" and on "Organized Prenatal Care." These two chapters have replaced the section in the first edition on "The Maternity Patient in the Community," and contain a fund of useful and valuable information. Statistics are given which emphasize the appalling mortality in this country from childbirth. "Childbirth still stands next to tuberculosis as a cause of death among women 15 to 44 years of age," says the author, and goes on to give figures showing the percentage according to nationalities and distribution of population.

The remedy for this condition lies in an educational program and Miss Van Blarcom points out the part to be played by the obstetrical nurse who loves her work and carries on with interest and enthusiasm. The hospital nurse has an important rôle, but the nurse working in the community and particularly in rural districts, has a wider scope for the exercise of her talents and influence. To quote a few lines:

> A large part of the value of good maternity nursing carried into patients' homes in rural communities or cities, is its educational effect. It makes more convincing and lasting impression than endless talk and writing.

A unique feature of this excellent volume is the author's idea of giving a variety of methods used in obstetrical nursing rather than holding to a technic used by only one hospital or by a particular obstetrician. Miss Van Blarcom states in the preface to the first edition that she has been convinced through her experience in teaching obstetrical nursing that this manner of presenting her subject will serve to broaden the nurse's attitude toward her work and her grasp of the entire subject.

Aside from the sound practical teachings of this book, its wealth of research material, and its charming style, it has something of inestimable value to the nurse. It reflects the high ethical standards of the author who imparts through these pages to her readers a respect and reverence for the mystery of a new life and surrounds motherhood with a beauty and charm so often forgotten in an all too practical and material world.

The book begins and ends with this quotation from Florence Nightingale:

> Can there be any higher work than this?
> Can any woman wish for a more womanly work?

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THE FUNDAMENTALS OF CHEMISTRY. By L. Jean Bogert, Ph.D. Second edition. 345 pages. 19 illustrations. W. B. Saunders Company, Philadelphia and London. 1928. Price, $2.75.

THIS second and revised edition of one of the more extensive textbooks adapted to the use of nurses' training schools will be welcomed, especially by those in a position to give a more or less extended course in their subject. The book contains about 7 per cent more textual material than was included in the first edition. The additional information is distributed more or less evenly among the various subdivisions of the subject which are usually treated in such a course; that is, elementary, inorganic, organic, and biological chemistry. Some attention is paid to the recent developments of the knowledge of the chemical structure

of the atom. The amount of discussion allowed this subject is sufficient to give the student some contact with these new ideas. This is certainly all that can be accomplished in the time available for teaching. A chapter upon the periodic law, together with such discussion of the quantitative aspects of the science as were presented previously, has been omitted. The logical development of the author's ideas does not seem to have been affected adversely by these changes. The omission of mathematical material is probably of distinct benefit. The majority of the students for whom the book is intended are not accustomed to thinking in terms of quantitative measurements, and they frequently seem to be confused rather than helped when numerical data are used to establish a fact or to illustrate an idea. A new feature in this edition is an introductory table designed to help the teacher use the text effectively. In this are shown those chapters of the book which can most profitably be omitted when short courses are given.

The question of the methods to be followed in teaching chemistry to a course of nurses is a most perplexing one to the instructor. He is asked to cover the subject from the most elementary conceptions usually given in high school, through various phases discussed at length in different college departments, to and including the application of the principles of the science to physiology and medicine taken usually during postgraduate instruction. Such a program is an absolutely stunning one, and the number of mistakes in method which can be made is legion. The book under discussion is certainly of value to the instructor who finds himself presenting inadequate material in an uninteresting manner, for it shows him what varied and extensive subjects can be effectively discussed, and how the discussion can be made interestingly. He must not be discouraged, however, if he tries to follow the text too closely. He may find that his pupils sometimes seem to be lost in a maze of detail, or are floundering rather awkwardly through a morass of theoretical ideas.

Every course for pupil nurses should emphasize practical points which have a direct bearing upon the work which she expects to do. By specifically mentioning facts which she will meet in practice, and pointing out in detail the relationships of these facts to their chemical background, the memory can often be induced to retain both the theoretical and practical ideas more accurately than it would otherwise do. There are many illustrations of this method of teaching given in Dr. Bogert's book which will be of great help to the instructor.

A third advantage which such a course in chemistry may bring to its students is preliminary contact with certain ideas dealt with in physiology and pathology. It is worth while to encroach somewhat upon the domain of those sciences, and to discuss, preferably from a chemical point of view, questions which will later be dealt with in more specialized courses. This repetition makes it more probable that the nurse will gain some comprehension of the ideas upon which much of her work is based. Such preliminary contact is excellently established by the material presented in the chapters of Dr. Bogert's book which take up digestion, metabolism, and the excretions.

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Some Other Books Worth Reading

ISABEL ELY LORD

Books for the Children

THERE is no time when children enjoy books more than when they have to spend their days in bed. Sometimes it is not advisable to let them read much, even if they are of an age to read for themselves, but it is a rare child that does not dote on being read to. First of all, they will probably call for the old favorites, books they have heard or read again and again. This is often hard on the adult reader, but the habit is one that should be encouraged always. Only too soon will they reach the age when most people think one reading of a book enough for all time. Even when the older reader gets to know the book by heart, the child still wants to hear it. He or she frequently knows it so well that part of it can be left to him or her. Many children like to have only the first part of a sentence read, to let them finish it. If the child is ill, it is of special importance to watch for the moment when he tires of this.

All children prefer books with pictures, and the younger they are, the more they like them. For children ill with a contagious disease the ten-cent store offers many old stories, in really attractive form, which can be burned afterward with little money loss. Stories like "The Little Red Hen" will keep a small child amused for many half-hours. But it is never safe to buy one of these cheap editions without first reading it, as many of the old favorites have been sadly changed by somebody. This is sometimes true of the more expensive editions, also, but not so often.

Of the recent picture books, none is more delightful than Wanda Gag's "Millions of Cats" ($1.25). Then there is a charming "Alphabet People," by Lois Lenski ($2.50), in which the rhymes are about the cook and the iceman, the teacher and the doctor, and other familiar folk. And Bernard and Elinor Darwin provide a new Tootletoo, this time "Tootletoo Two" ($2).

Tony Sarg's books are usually classed as picture books, but his latest, "Tony Sarg's Book of Tricks" ($5), is for boys or girls old enough to appreciate the tricks he describes. It will offer the right child lots of material for the happy "well" days to come. A. A. Milne has added to "Winnie the Pooh," "The House at Pooh Corner," ($2) and this must not be missed by any child old enough to enjoy it. Hugh Lofting has given us another "Doctor Doolittle" book; this time he is "In the Moon" ($2.50). Fairy stories never fail in charm, and there is a fine new collection brought together from many countries by Romer Wilson, and called "Green Magic" ($2.50). For a good retelling of old tales, Veronica S. Hutchinson gives us "Candlelight Stories" ($2).

As a guide to choosing books for children there is no one quite so good as Anne Carroll Moore, the head of the children's work of the New York Public Library. Her latest volume is "The Three Owls" ($3), made up from her weekly page in the Sunday *New York Herald-Tribune*, and covering the books of the last three years. Miss Moore would be the first to say, "Not too many *new* books. Old friends are best."

Official Directory

International Council of Nurses.—Sec., Christiane Reimann, 14 Quai des Eaux Vives, Geneva, Switzerland.

The American Journal of Nursing Company. Offices, 370 Seventh Ave., New York. —Pres., Bena M. Henderson, Milwaukee Children's Hospital, Milwaukee, Wis. Sec., Stella Goostray, Children's Hospital, Boston. Treas., Mary M. Riddle, care American Journal of Nursing, New York, N. Y. Elsie M. Lawler, Baltimore; Sally Johnson, Boston; Mrs. Elsbeth Vaughan, St. Louis; Elizabeth G. Fox, Washington, D. C.

Committee on the Grading of Nursing Schools.—Director, May Ayres Burgess, Ph.D., 370 Seventh Ave., New York.

The American Nurses' Association.—Headquarters, 370 Seventh Ave., New York. Pres., S. Lillian Clayton, Philadelphia General Hospital, Philadelphia, Pa. Sec., Susan C. Francis, Children's Hospital, Philadelphia, Pa. Treas., Jessie E. Catton, New England Hospital for Women and Children, Dimock St., Boston 19, Mass. Headquarters Dir., Janet M. Geister, 370 Seventh Ave., New York. Sections: **Private Duty,** Chairman, Anna E. Gladwin, 268 E. Voris St., Akron, O. **Mental Hygiene,** Chairman, Effie J. Taylor, New Haven Hospital, New Haven, Conn. **Legislation,** Chairman, Josephine E. Thurlow, Cambridge Hospital, Cambridge, Mass. **Government Nursing Service,** Chairman, Elinor D. Gregg, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C. **Relief Fund Committee,** Chairman, Carrie M. Hall, Peter Bent Brigham Hospital, Boston. **Revision Committee,** Chairman, Marie Louis, Muhlenberg Hospital, Plainfield, N. J.

The National League of Nursing Education.—Headquarters, 370 Seventh Ave., New York. Pres., Elizabeth C. Burgess, Teachers College, New York. Sec., Stella Goostray, Children's Hospital, Boston. Treas., Marian Rottman, Bellevue Hospital, New York. Ex. Sec., Nina D. Gage, 370 Seventh Ave., New York.

The National Organization for Public Health Nursing.—Pres., Mrs. Anne L. Hansen, 181 Franklin St., Buffalo, N. Y. Director, Katharine Tucker, 370 Seventh Ave., New York.

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